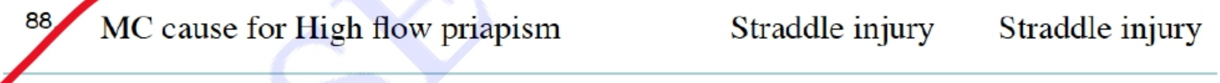
28/59 Urology questions from viSE lectures/mnemonics
20/59 Urology questions from viSE urology mock tests
14/40 General Surgery questions from viSE General Surg mock tests

Contact us at: 9014516775
Follow us at:
UROLOGY: https://www.facebook.com/viseurology/
GENERAL SURGERY : https://www.facebook.com/viseGeneralSurgery/
GI SURGERY: https://www.facebook.com/viseGISURGERY/

VISE MEDACADEMY 2020

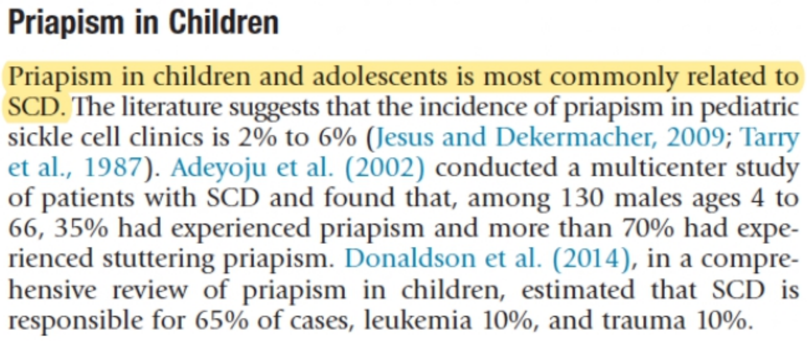
1. Most common cause of priapism in a child is
A. SCD
B. Trauma
C. Drugs
D. Leukaemia

Answer : A
Explanation:
VISE URO MOCK 1 Q NO 88



88	MC cause for High flow priapism	Straddle injury	Straddle injury

Campbell Text Book Of Urology 12th Edition, Chapter No.70, page no.1546



Priapism in Children

Priapism in children and adolescents is most commonly related to SCD. The literature suggests that the incidence of priapism in pediatric sickle cell clinics is 2% to 6% (Jesus and Dekermacher, 2009; Tarry et al., 1987). Adeyoju et al. (2002) conducted a multicenter study of patients with SCD and found that, among 130 males ages 4 to 66, 35% had experienced priapism and more than 70% had experienced stuttering priapism. Donaldson et al. (2014), in a comprehensive review of priapism in children, estimated that SCD is responsible for 65% of cases, leukemia 10%, and trauma 10%.

2. A patient has GFR of 45 ml. He falls into which CKD class

A Stage 1

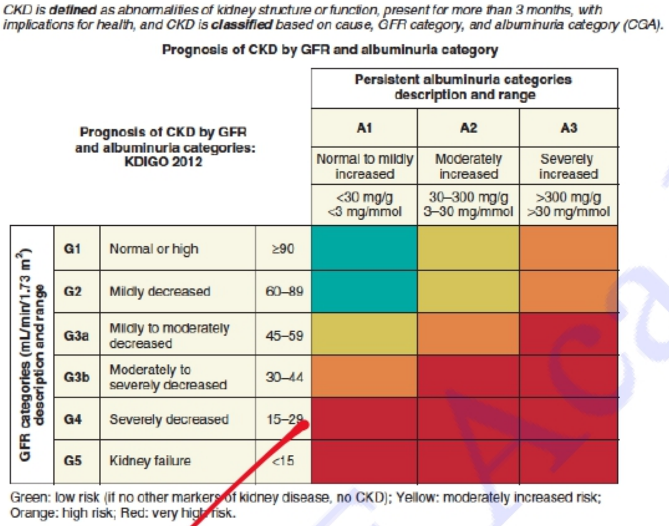
B. Stage 2

C. Stage 3

D. Stage 4

Answer : C

Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No. 87, Page No. 1928



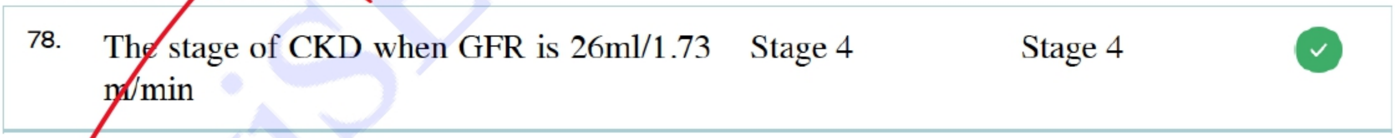
CKD is ***defined*** *as abnormalities of kidney structure or function, present for more than 3 months, with implications for health, and CKD is* ***classified*** *based on cause, GFR category, and albuminuria category (CGA).*

Prognosis of CKD by GFR and albuminuria category

Prognosis of CKD by GFR and albuminuria categories: KDIGO 2012				**Persistent albuminuria categories description and range**		
				A1	**A2**	**A3**
				Normal to mildly increased	Moderately increased	Severely increased
				<30 mg/g <3 mg/mmol	30–300 mg/g 3–30 mg/mmol	>300 mg/g >30 mg/mmol
GFR categories ($mL/min/1.73\ m^2$) description and range	**G1**	Normal or high	≥90	🟩	🟨	🟧
	G2	Mildly decreased	60–89	🟩	🟨	🟧
	G3a	Mildly to moderately decreased	45–59	🟨	🟧	🟥
	G3b	Moderately to severely decreased	30–44	🟧	🟥	🟥
	G4	Severely decreased	15–29	🟥	🟥	🟥
	G5	Kidney failure	<15	🟥	🟥	🟥

Green: low risk (if no other markers of kidney disease, no CKD); Yellow: moderately increased risk; Orange: high risk; Red: very high risk.

VISE URO MOCK 5 Q NO 78



78. The stage of CKD when GFR is 26ml/1.73 m/min Stage 4 Stage 4 ✓

VISE TRANSPLANT LECTURE NOTES

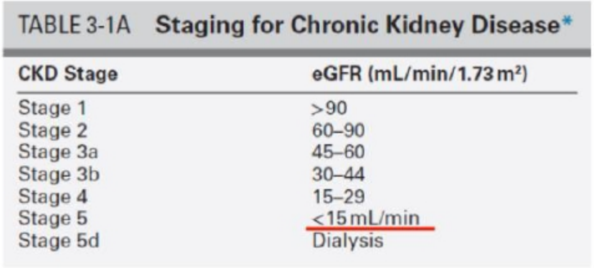
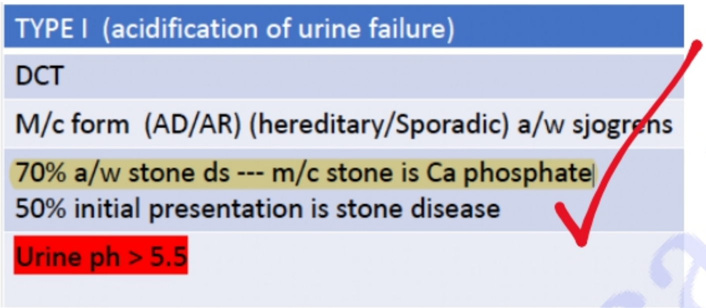


TABLE 3-1A **Staging for Chronic Kidney Disease***

CKD Stage	**eGFR ($mL/min/1.73\,m^2$)**
Stage 1	>90
Stage 2	60–90
Stage 3a	45–60
Stage 3b	30–44
Stage 4	15–29
Stage 5	<15 mL/min
Stage 5d	Dialysis

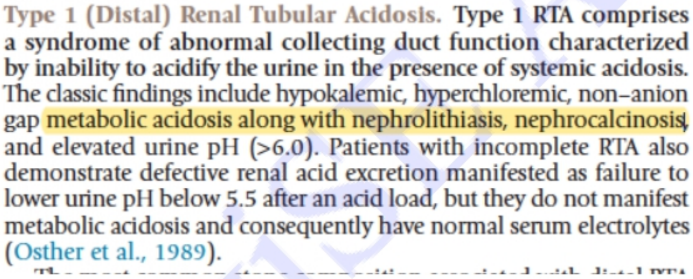
3. Urolithiasis is commonly seen in which type of renal tubular acidosis
A.Type 1
B. Type 2
C.Type4
D. Proximal RTA

Answer : A
Explanation: VISE URO LECTURE NOTES- STONE DISEASE-PAGE 53
VISE 6 PM MCQS SERIES-22- Q.NO 9



TYPE I (acidification of urine failure)
DCT
M/c form (AD/AR) (hereditary/Sporadic) a/w sjogrens
70% a/w stone ds --- m/c stone is Ca phosphate 50% initial presentation is stone disease
Urine ph > 5.5

Campbell Text Book Of Urology 12th Edition, Chapter No. 91, Page No.2025



Type 1 (Distal) Renal Tubular Acidosis. Type 1 RTA comprises a syndrome of abnormal collecting duct function characterized by inability to acidify the urine in the presence of systemic acidosis. The classic findings include hypokalemic, hyperchloremic, non–anion gap metabolic acidosis along with nephrolithiasis, nephrocalcinosis, and elevated urine pH (>6.0). Patients with incomplete RTA also demonstrate defective renal acid excretion manifested as failure to lower urine pH below 5.5 after an acid load, but they do not manifest metabolic acidosis and consequently have normal serum electrolytes (Osther et al., 1989).

4. Chromosomal mutation seen in ADPKD
A.13
B.14
C.16
D.19
Answer : C
Explanation:

VISE URO LECTURE NOTES- PEDIATRIC UROLOGY-PAGE 63

Campbell Text Book Of Urology 12th Edition, Chapter No.39, Page No.751

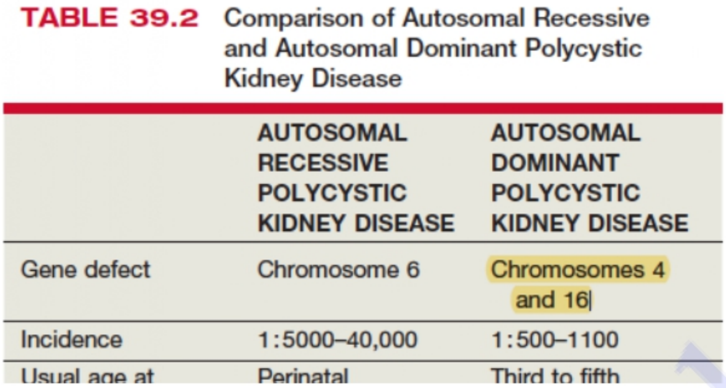


TABLE 39.2 Comparison of Autosomal Recessive and Autosomal Dominant Polycystic Kidney Disease

	AUTOSOMAL RECESSIVE POLYCYSTIC KIDNEY DISEASE	AUTOSOMAL DOMINANT POLYCYSTIC KIDNEY DISEASE
Gene defect	Chromosome 6	Chromosomes 4 and 16
Incidence	1:5000–40,000	1:500–1100
Usual age at	Perinatal	Third to fifth

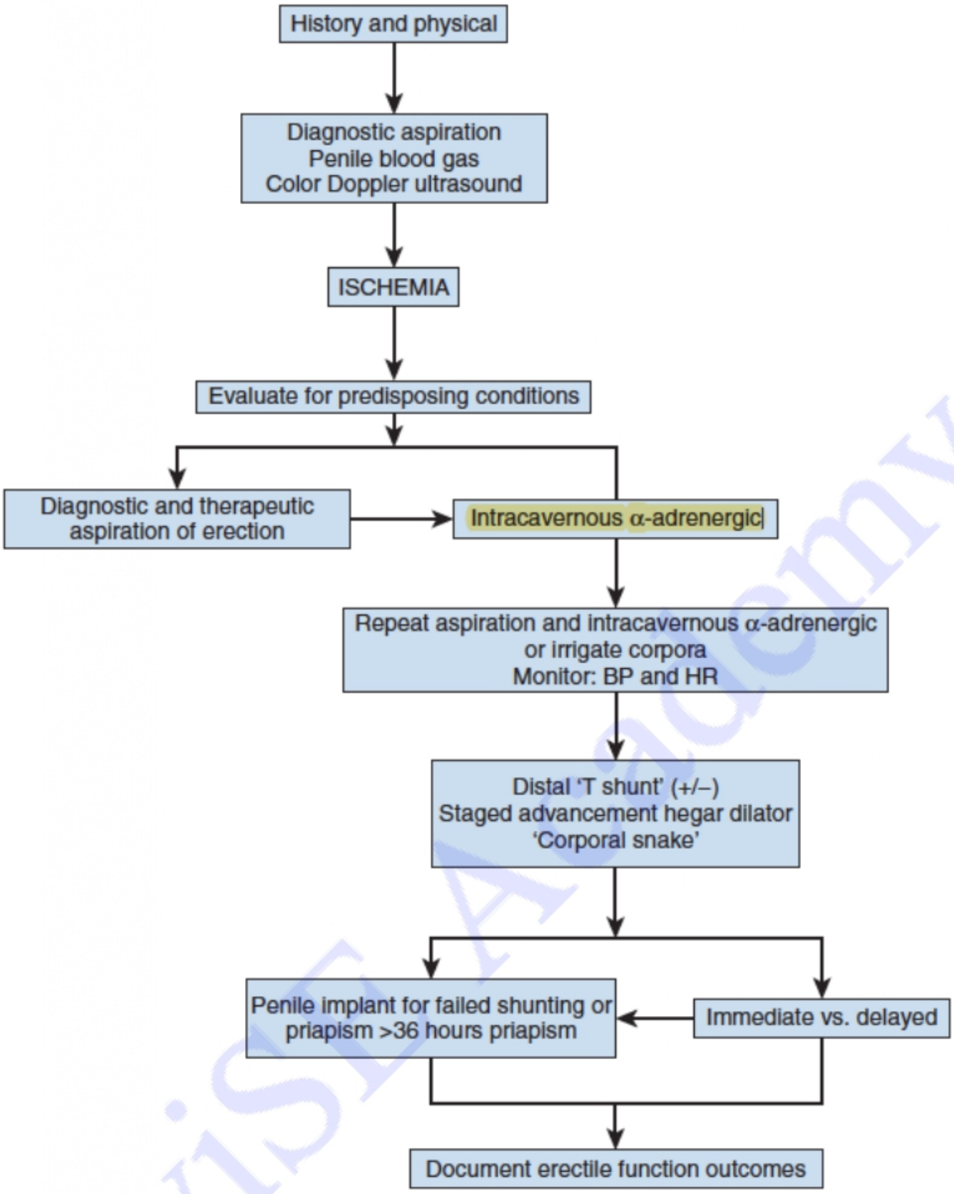
5. A 32 yr old young man presented with complaint of painful erection, penile blood ABG is s/o
P02- 23,pco2- 63,what is the diagnosis and next management

A. Ischemic Priapism -Aspiration & T Shunt
B. Ischemic Priapism -Aspiration& Intracavernosal Alpha Adrenergic Agonist
C. Ischemic Priapism-Aspiration& Intracavernosal Alpha Blocker
D. Ischemic Priapism -Aspiration&Proximal Shunt

Answer : B

EXPLANATION: VISE 6 PM MCQS SERIES-25- Q.NO 5

Campbell Text Book Of Urology 12th Edition, Chapter No.70, page no. 1551


History and physical
Diagnostic aspiration
Penile blood gas
Color Doppler ultrasound
ISCHEMIA
Evaluate for predisposing conditions
Diagnostic and therapeutic aspiration of erection
Intracavernous α-adrenergic
Repeat aspiration and intracavernous α-adrenergic or irrigate corpora
Monitor: BP and HR
Distal 'T shunt' (+/–)
Staged advancement hegar dilator
'Corporal snake'
Penile implant for failed shunting or priapism >36 hours priapism
Immediate vs. delayed
Document erectile function outcomes

viSL Academy

Fig. 70.7. Algorithm for managing ischemic priapism. *BP,* Blood pressure; *ECG,* electrocardiogram; *HR,* heart rate.

6. Captopril renogram done for diagnosis of which disorder

A. Diabetic nephropathy

B. Renal artery stenosis

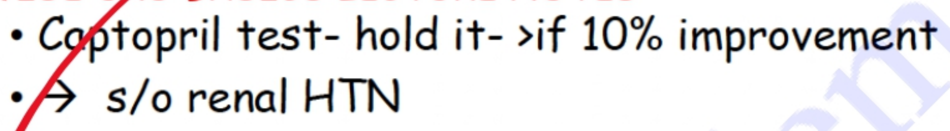
C. Pujo

D. None of these

Answer : B

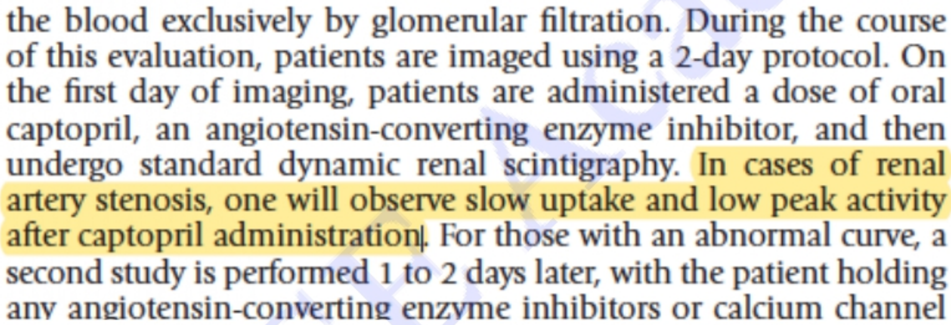
Explanation:

VISE URO BASICS LECTURE NOTES



- Captopril test- hold it- >if 10% improvement
- → s/o renal HTN

Campbell Text Book Of Urology 12th Edition, Chapter No.5, Page No.94



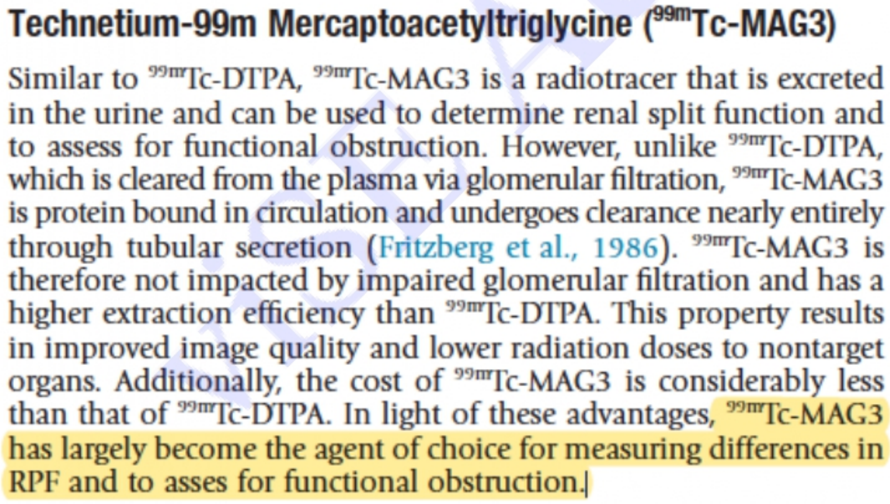
the blood exclusively by glomerular filtration. During the course of this evaluation, patients are imaged using a 2-day protocol. On the first day of imaging, patients are administered a dose of oral captopril, an angiotensin-converting enzyme inhibitor, and then undergo standard dynamic renal scintigraphy. In cases of renal artery stenosis, one will observe slow uptake and low peak activity after captopril administration. For those with an abnormal curve, a second study is performed 1 to 2 days later, with the patient holding any angiotensin-converting enzyme inhibitors or calcium channel

7. Patient with suspected puj obstruction is best diagnosed by
A. CT angiogrm
B. DMSA
C. MAG3
D. IVU
Answer : C
Explanation:

VISE URO BASICS LECTURE NOTES

- 99mTc-MAG3 is preferred at most centers over 99mTc-DTPA
- because it has a higher extraction efficiency and is less
- affected by changes in renal function.

Campbell Text Book Of Urology 12th Edition, Chapter No. 5 , Page No. 92



Technetium-99m Mercaptoacetyltriglycine (^{99m}Tc-MAG3)

Similar to ^{99m}Tc-DTPA, ^{99m}Tc-MAG3 is a radiotracer that is excreted in the urine and can be used to determine renal split function and to assess for functional obstruction. However, unlike ^{99m}Tc-DTPA, which is cleared from the plasma via glomerular filtration, ^{99m}Tc-MAG3 is protein bound in circulation and undergoes clearance nearly entirely through tubular secretion (Fritzberg et al., 1986). ^{99m}Tc-MAG3 is therefore not impacted by impaired glomerular filtration and has a higher extraction efficiency than ^{99m}Tc-DTPA. This property results in improved image quality and lower radiation doses to nontarget organs. Additionally, the cost of ^{99m}Tc-MAG3 is considerably less than that of ^{99m}Tc-DTPA. In light of these advantages, ^{99m}Tc-MAG3 has largely become the agent of choice for measuring differences in RPF and to asses for functional obstruction.

8. 25 year female with diagnosed with Puj Obstruction, raised serum creatinine, renal function 75% & 25%, what is the next step best step
A. Pyeloplasty
B. Endopyelomyotomy
C. Ct angiography
D. Stenting

Answer: A
Explanation:
VISE URO MOCK 1 Q NO 64 on AH pyeloplasty
Vise Uro Lecture notes- Pediatric urology-page 81
Campbell Text Book Of Urology 12th Edition, Chapter No. 89, Page No. 1946

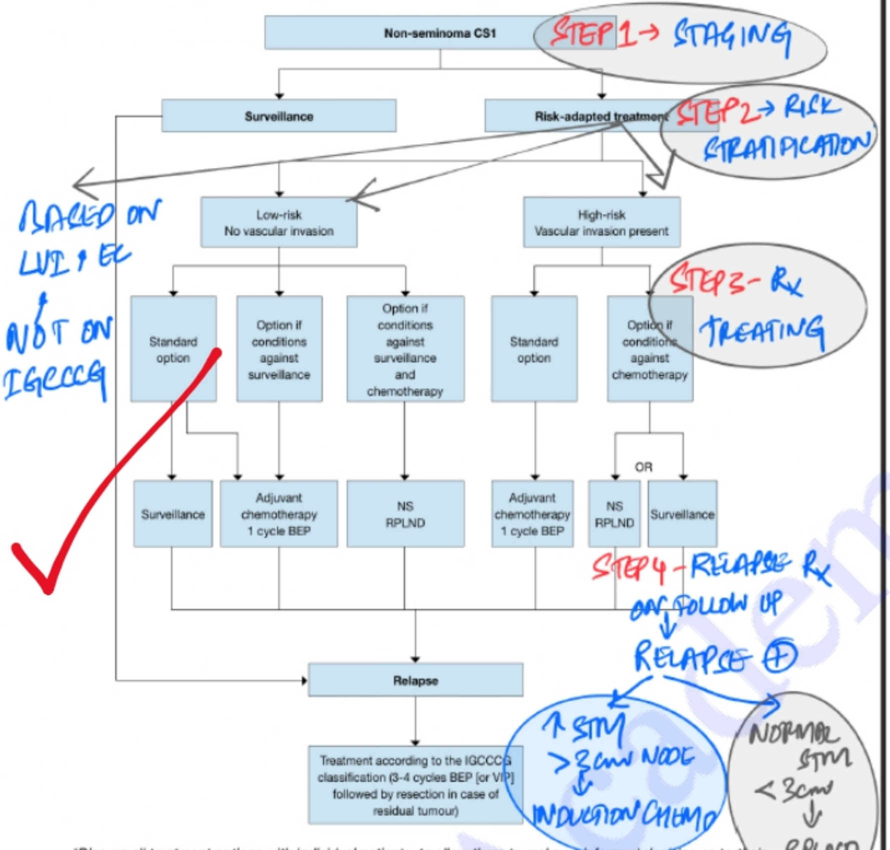
9. 4cm testicular mass, confined to testis (45%teratoma,40% seminoma, 15%ec). Post orchidectomy tumour markers normal. CT showing 4 mm, inguinal node.No metastasis .best next step is.
A. ACTIVE SURVEILLANCE
B. RT
C. RPLND f/b BEPx2
D. BEPx3

Answer : A
Explanation: VISE URO LECTURE NOTES- CA TESTIS -PAGE 60
Campbell Text Book Of Urology 12th Edition, Chapter No. 76, Page No.1693
For suspected mets ln should be more 5-9 mm to be considered to be significant here it is 4mm size.
For EC predominance percentage of EC should be 40to90% so it's a low risk and as is better option.

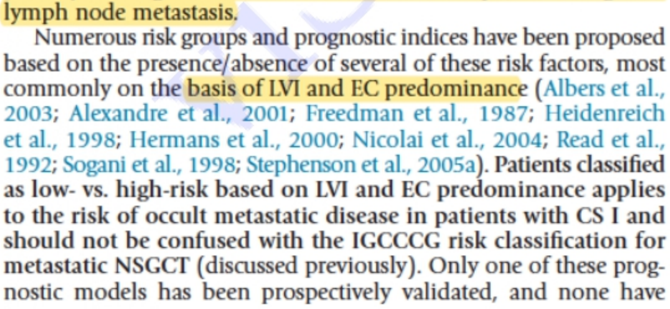
Koushik Sharm

AS
RPLND
1 CYCLE BEP

Figure 1: Risk-adapted treatment in patients with clinical stage I non-seminoma NSGCT [163]*


Non-seminoma CS1
STEP 1 → STAGING
Surveillance
Risk-adapted treatment
STEP 2 → RISK STRATIFICATION
BASED ON LVI & EC
NOT ON IGCCCG
Low-risk
No vascular invasion
High-risk
Vascular invasion present
STEP 3 - Rx TREATING
Standard option
Option if conditions against surveillance
Option if conditions against surveillance and chemotherapy
Standard option
Option if conditions against chemotherapy
OR
Surveillance
Adjuvant chemotherapy 1 cycle BEP
NS RPLND
Adjuvant chemotherapy 1 cycle BEP
NS RPLND
Surveillance
STEP 4 - RELAPSE Rx
ON FOLLOW UP
RELAPSE ⊕
Relapse
Treatment according to the IGCCCG classification (3-4 cycles BEP [or VIP] followed by resection in case of residual tumour)
↑ STM
>3cm NODE
INDUCTION CHEMO
NORMAL STM
<3cm
RPLND

*Discuss all treatment options with individual patients, to allow them to make an informed decision as to their further care.



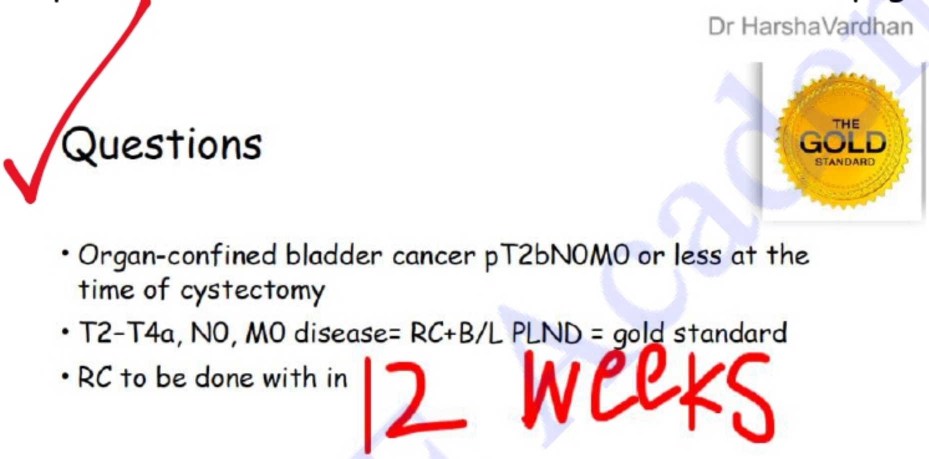
As discussed previously, the results of abdominal-pelvic CT imaging should be considered when formulating treatment recommendations because a size cutoff of 1 cm is associated with a high false-negative rate. Retroperitoneal lymph nodes greater than 5 to 9 mm in the primary landing zone should be viewed with suspicion for regional lymph node metastasis.

Numerous risk groups and prognostic indices have been proposed based on the presence/absence of several of these risk factors, most commonly on the basis of LVI and EC predominance (Albers et al., 2003; Alexandre et al., 2001; Freedman et al., 1987; Heidenreich et al., 1998; Hermans et al., 2000; Nicolai et al., 2004; Read et al., 1992; Sogani et al., 1998; Stephenson et al., 2005a). **Patients classified as low- vs. high-risk based on LVI and EC predominance applies to the risk of occult metastatic disease in patients with CS I and should not be confused with the IGCCCG risk classification for metastatic NSGCT** (discussed previously). Only one of these prognostic models has been prospectively validated, and none have

10. 40 year old gentleman diagnosed with Carcinoma Bladder In Trigone Area and staged as PT2A NO M0
He has a grade 3a & creatinine clearance 45ml. Serum creatinine 1.51, NA-135,CL-99,K-4.5,what is the next best management plan for him:
A. RADICAL CYSTECTOMY
B. MAXIMUM TURBT+RT
C. MAXIMUM TURBT + CHEMOTHERAPY
D. NEOADJUVANT CHEMO+RADICAL CYSTECTOMY + ORTHOTOPIC NEO BLADDER RECONSTRUCTION

Answer : A

Explanation: Vise Uro Lecture notes- Ca bladder -page no 12


Dr HarshaVardhan

Questions

THE GOLD STANDARD

- Organ-confined bladder cancer pT2bN0M0 or less at the time of cystectomy
- T2-T4a, N0, M0 disease= RC+B/L PLND = gold standard
- RC to be done with in 12 weeks

Campbell Text Book Of Urology 12th Edition, Chapter No.137 Page No.3114-3116

11. In a case Of Lap Donor Nephrectomy last to ligate

A. Ureter
B. Vein renal
C. RENAL ARTERY
D. Gonadal vein

Answer : B

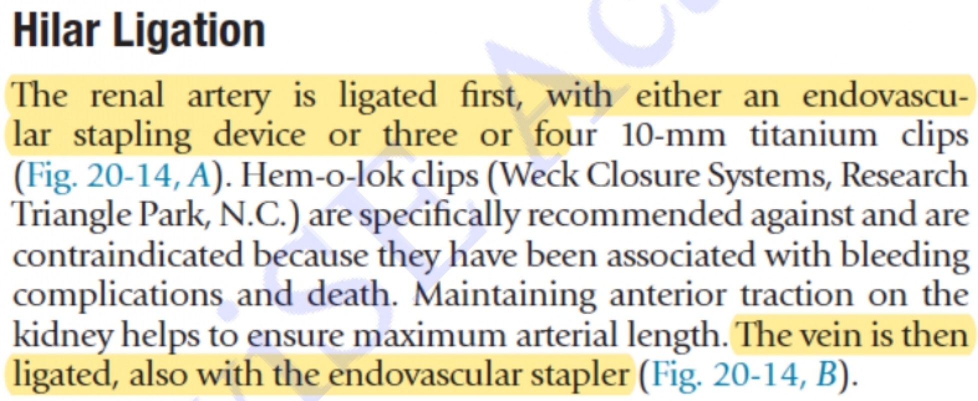
Explanation:

VISE URO TRANSPLANT LECTURE SERIES DETAILED DISCUSSION OF THIS CONCEPT

Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No. , Page No.

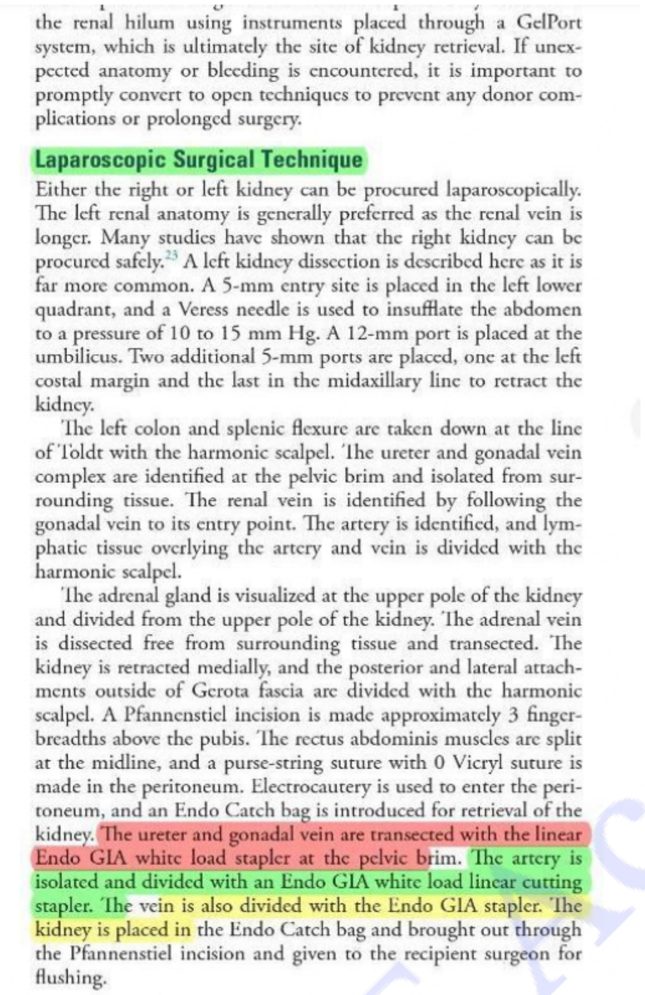
Atlas of laparoscopic and robotic urologic surgery- 3rd edition-chapter 20,page 148

Atlas of laparoscopic and robotic urologic surgery- 3rd edition-chapter 20,page 148



Hilar Ligation

The renal artery is ligated first, with either an endovascular stapling device or three or four 10-mm titanium clips (Fig. 20-14, A). Hem-o-lok clips (Weck Closure Systems, Research Triangle Park, N.C.) are specifically recommended against and are contraindicated because they have been associated with bleeding complications and death. Maintaining anterior traction on the kidney helps to ensure maximum arterial length. The vein is then ligated, also with the endovascular stapler (Fig. 20-14, B).



the renal hilum using instruments placed through a GelPort system, which is ultimately the site of kidney retrieval. If unexpected anatomy or bleeding is encountered, it is important to promptly convert to open techniques to prevent any donor complications or prolonged surgery.

Laparoscopic Surgical Technique

Either the right or left kidney can be procured laparoscopically. The left renal anatomy is generally preferred as the renal vein is longer. Many studies have shown that the right kidney can be procured safely.[23] A left kidney dissection is described here as it is far more common. A 5-mm entry site is placed in the left lower quadrant, and a Veress needle is used to insufflate the abdomen to a pressure of 10 to 15 mm Hg. A 12-mm port is placed at the umbilicus. Two additional 5-mm ports are placed, one at the left costal margin and the last in the midaxillary line to retract the kidney.

The left colon and splenic flexure are taken down at the line of Toldt with the harmonic scalpel. The ureter and gonadal vein complex are identified at the pelvic brim and isolated from surrounding tissue. The renal vein is identified by following the gonadal vein to its entry point. The artery is identified, and lymphatic tissue overlying the artery and vein is divided with the harmonic scalpel.

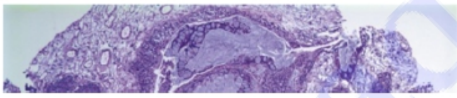
The adrenal gland is visualized at the upper pole of the kidney and divided from the upper pole of the kidney. The adrenal vein is dissected free from surrounding tissue and transected. The kidney is retracted medially, and the posterior and lateral attachments outside of Gerota fascia are divided with the harmonic scalpel. A Pfannenstiel incision is made approximately 3 fingerbreadths above the pubis. The rectus abdominis muscles are split at the midline, and a purse-string suture with 0 Vicryl suture is made in the peritoneum. Electrocautery is used to enter the peritoneum, and an Endo Catch bag is introduced for retrieval of the kidney. The ureter and gonadal vein are transected with the linear Endo GIA white load stapler at the pelvic brim. The artery is isolated and divided with an Endo GIA white load linear cutting stapler. The vein is also divided with the Endo GIA stapler. The kidney is placed in the Endo Catch bag and brought out through the Pfannenstiel incision and given to the recipient surgeon for flushing.

Sabiston 20th edition, chapter 26 page 652

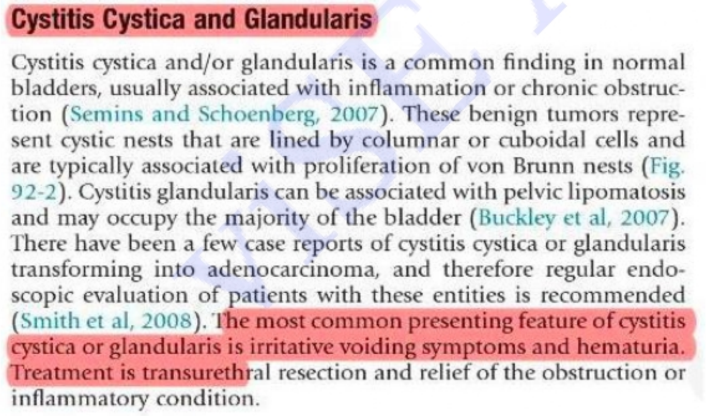
12. CYSTITIS GRANDULARIS the most common presentation is:
A. Hematruia
B. Irritative voiding symptoms
C. Dysuria
D. Boo
Answer : B
Explanation:

VISE URO ONCOLOGY - CA BLADDER SESSION

- **Cystitis cystica and glandularis**
  - Inflammation or chronic obstruction
  - Proliferation of von brunn nests
  - Cystitis glandularis may be associated with pelvic lipomatosis.
  - Adenocarcinoma-low risk of progression
  - Transurethral resection and relief of the obstruction or inflammatory condition.



Campbell Text Book Of Urology 11th Edition, Chapter No.92, page no.2185



Cystitis Cystica and Glandularis

Cystitis cystica and/or glandularis is a common finding in normal bladders, usually associated with inflammation or chronic obstruction (Semins and Schoenberg, 2007). These benign tumors represent cystic nests that are lined by columnar or cuboidal cells and are typically associated with proliferation of von Brunn nests (Fig. 92-2). Cystitis glandularis can be associated with pelvic lipomatosis and may occupy the majority of the bladder (Buckley et al, 2007). There have been a few case reports of cystitis cystica or glandularis transforming into adenocarcinoma, and therefore regular endoscopic evaluation of patients with these entities is recommended (Smith et al, 2008). The most common presenting feature of cystitis cystica or glandularis is irritative voiding symptoms and hematuria. Treatment is transurethral resection and relief of the obstruction or inflammatory condition.

13. Mid stream urine sample corresponds to:

A. VB 1
B. EPS
C. VB 2
D. VB 3

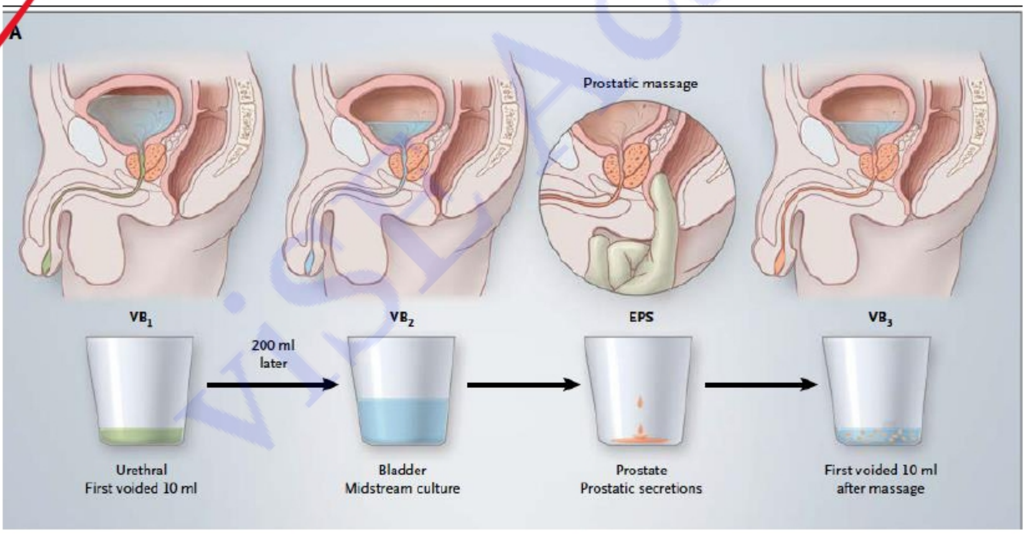
Answer : C

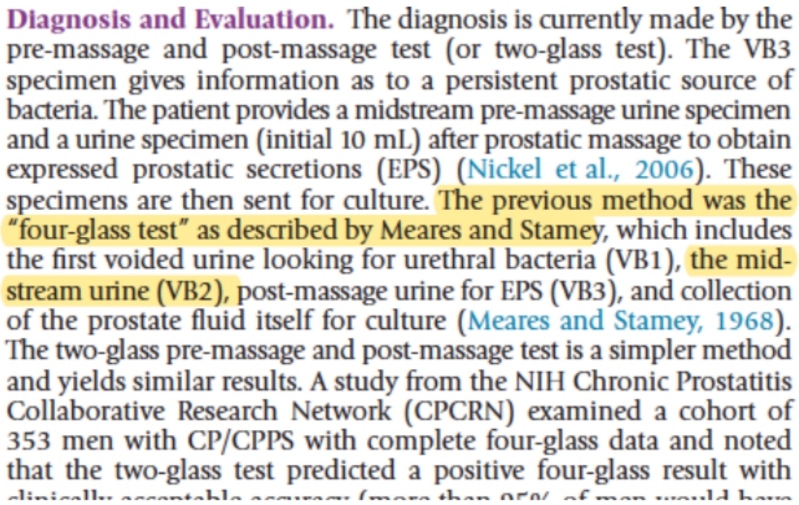
Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No.56, Page No. 1206

VISE URO MOCK 2 Q NO 83,

83.	Correct order in Meares and Stamey – four glass test	VB1,VB2,EPS,VB 3	VB1,VB2,EPS,VB3

VISE URO BASICS LECTURE NOTES


A
Prostatic massage
VB1
200 ml later
VB2
EPS
VB3
Urethral
First voided 10 ml
Bladder
Midstream culture
Prostate
Prostatic secretions
First voided 10 ml
after massage



Diagnosis and Evaluation. The diagnosis is currently made by the pre-massage and post-massage test (or two-glass test). The VB3 specimen gives information as to a persistent prostatic source of bacteria. The patient provides a midstream pre-massage urine specimen and a urine specimen (initial 10 mL) after prostatic massage to obtain expressed prostatic secretions (EPS) (Nickel et al., 2006). These specimens are then sent for culture. The previous method was the "four-glass test" as described by Meares and Stamey, which includes the first voided urine looking for urethral bacteria (VB1), the midstream urine (VB2), post-massage urine for EPS (VB3), and collection of the prostate fluid itself for culture (Meares and Stamey, 1968). The two-glass pre-massage and post-massage test is a simpler method and yields similar results. A study from the NIH Chronic Prostatitis Collaborative Research Network (CPCRN) examined a cohort of 353 men with CP/CPPS with complete four-glass data and noted that the two-glass test predicted a positive four-glass result with

14. Crystal which doesn't precipitate in acidic urine

A. Phosphate

B. Uric acid

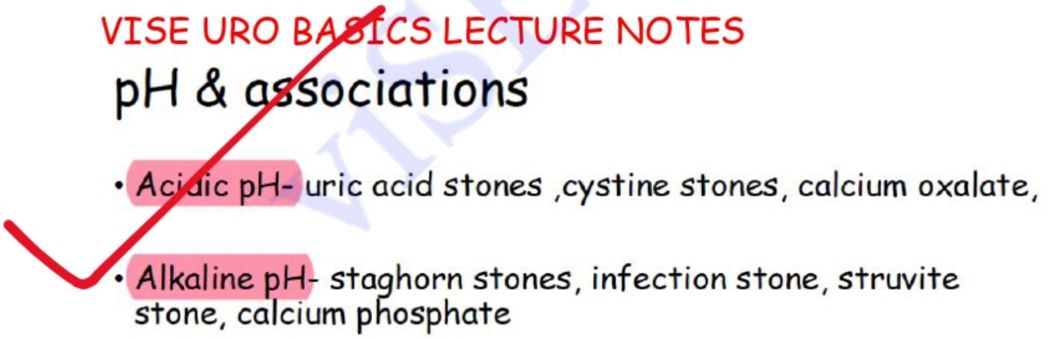
C. Ca oxalate

D. Cysteine

Answer : A

Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No. 91, Page No. 2027

VISE URO BASICS LECTURE NOTES



pH & associations

- Acidic pH- uric acid stones ,cystine stones, calcium oxalate,
- Alkaline pH- staghorn stones, infection stone, struvite stone, calcium phosphate

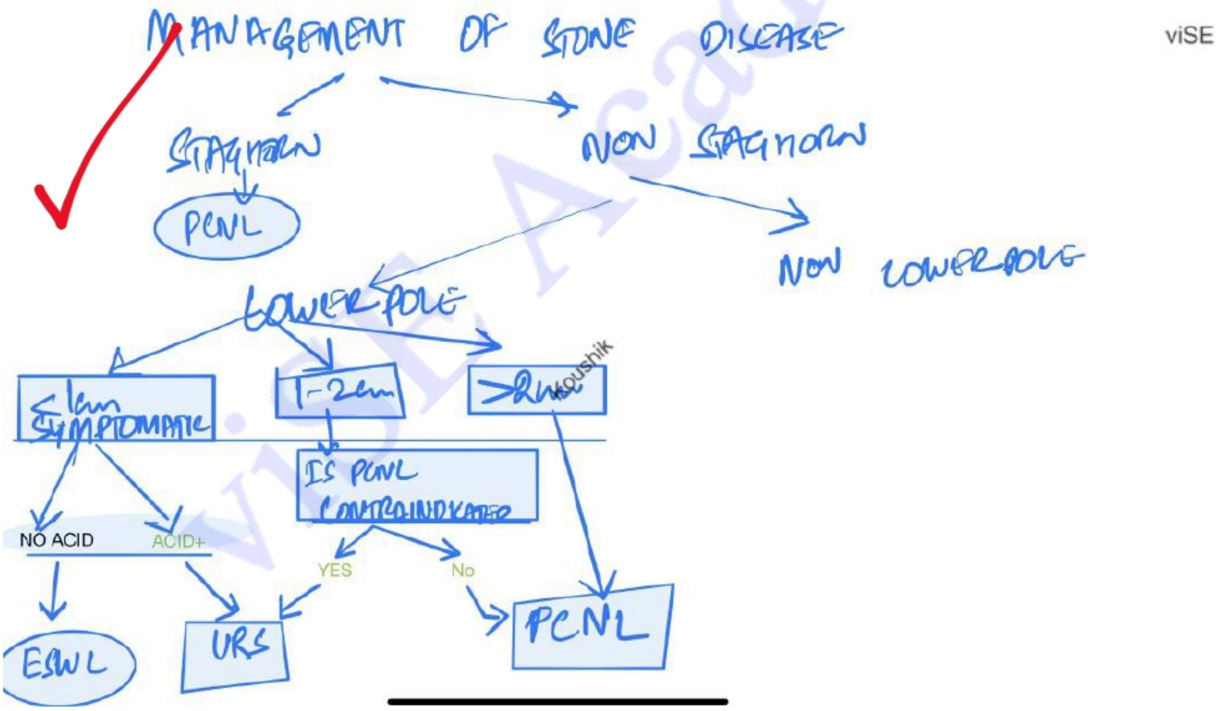
15. A patient found to have 1.5 cm stone in renal pelvis and he has coagulopathy. The best management of stone in this patient is

A. ESWL
B. ESWL AFTER FFP
C. FLEXIBLE URS
D. PCNL

Answer: C

Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No.93, Page No. 2072

VISE URO STONE DISEASE LECTURE NOTES page no 104-
The ACID factor mnemonic


MANAGEMENT OF STONE DISEASE
viSE
STAGHORN
PCNL
NON STAGHORN
NON LOWER POLE
LOWER POLE
<1cm SYMPTOMATIC
1-2cm
>2cm
IS PCNL CONTRAINDICATED
NO ACID
ACID+
YES
No
ESWL
URS
PCNL

16. Golf hole ureter is seen in

A. Tuberculosis.

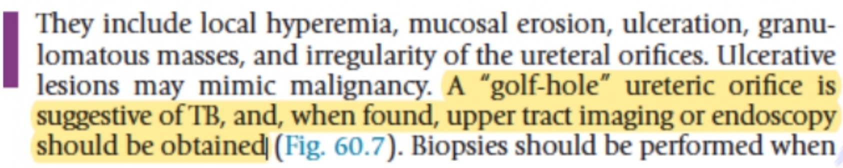
B. Ca bladder

C. Schistosomiasis

D. E.coli infection

Answer : A

Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No.1314 , Page No.1314



They include local hyperemia, mucosal erosion, ulceration, granulomatous masses, and irregularity of the ureteral orifices. Ulcerative lesions may mimic malignancy. A "golf-hole" ureteric orifice is suggestive of TB, and, when found, upper tract imaging or endoscopy should be obtained (Fig. 60.7). Biopsies should be performed when

17. Ureteric bud develops from

A. Mesonephric

B. Paramesonephric

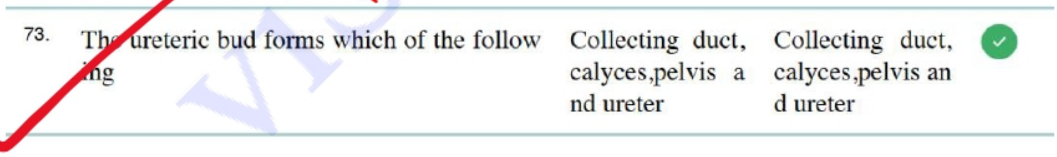
C. Urogenital sinus

D. None of these

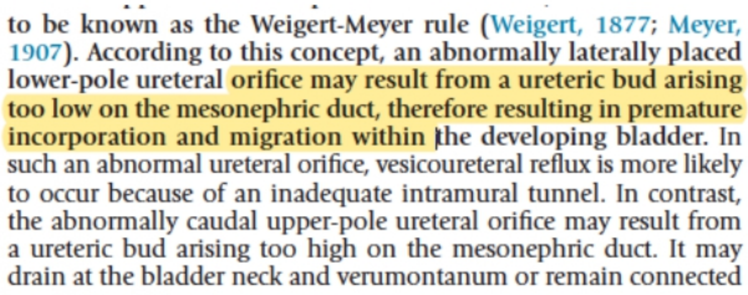
Answer : A

Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No. 20, Page No. 320

VISE URO MOCK 5 Q 73

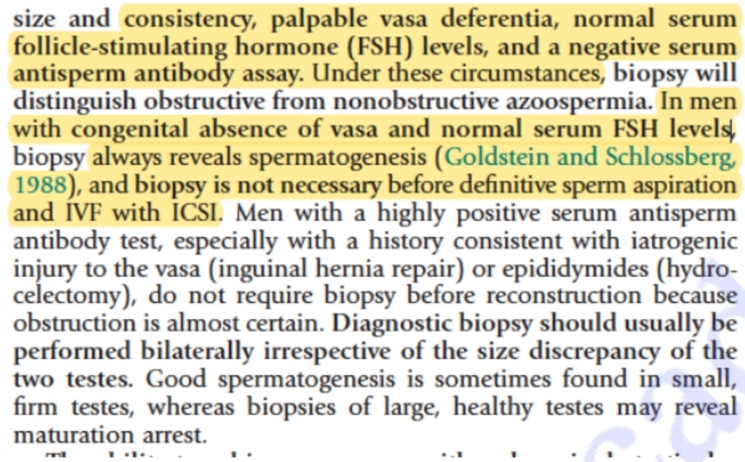


73.	The ureteric bud forms which of the following	Collecting duct, calyces,pelvis and ureter	Collecting duct, calyces,pelvis and ureter	✓



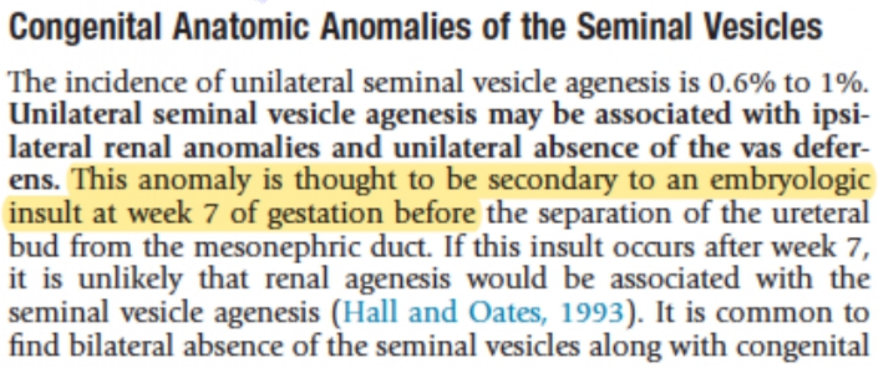
to be known as the Weigert-Meyer rule (Weigert, 1877; Meyer, 1907). According to this concept, an abnormally laterally placed lower-pole ureteral orifice may result from a ureteric bud arising too low on the mesonephric duct, therefore resulting in premature incorporation and migration within the developing bladder. In such an abnormal ureteral orifice, vesicoureteral reflux is more likely to occur because of an inadequate intramural tunnel. In contrast, the abnormally caudal upper-pole ureteral orifice may result from a ureteric bud arising too high on the mesonephric duct. It may drain at the bladder neck and verumontanum or remain connected

18. Testis biopsy least helpful in
A. Evaluation of Bilateral Absent Vas With Normal FSH
B. Inability to retrieve motile sperm from epididymis
C. Evaluation of Non Obstructive Azoospermia
D. None of these
Answer : A
Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No.66, Page No. 1447/1445.E2



size and consistency, palpable vasa deferentia, normal serum follicle-stimulating hormone (FSH) levels, and a negative serum antisperm antibody assay. Under these circumstances, biopsy will distinguish obstructive from nonobstructive azoospermia. In men with congenital absence of vasa and normal serum FSH levels, biopsy always reveals spermatogenesis (Goldstein and Schlossberg, 1988), and biopsy is not necessary before definitive sperm aspiration and IVF with ICSI. Men with a highly positive serum antisperm antibody test, especially with a history consistent with iatrogenic injury to the vasa (inguinal hernia repair) or epididymides (hydrocelectomy), do not require biopsy before reconstruction because obstruction is almost certain. Diagnostic biopsy should usually be performed bilaterally irrespective of the size discrepancy of the two testes. Good spermatogenesis is sometimes found in small, firm testes, whereas biopsies of large, healthy testes may reveal maturation arrest.

19. Congenital U/L absence of Vas Deferens and ipsilateral renal agenesis ,the likely developmental reason is
A.CFTR gene mutation
B. insult of mesonephric duct before 7th week
C. No association between these two anomalies
D. none of the above
Answer : B
Explanation: Campbell Text Book Of Urology 11th Edition, Chapter No.41, Page No.958



Congenital Anatomic Anomalies of the Seminal Vesicles

The incidence of unilateral seminal vesicle agenesis is 0.6% to 1%. **Unilateral seminal vesicle agenesis may be associated with ipsilateral renal anomalies and unilateral absence of the vas deferens.** This anomaly is thought to be secondary to an embryologic insult at week 7 of gestation before the separation of the ureteral bud from the mesonephric duct. If this insult occurs after week 7, it is unlikely that renal agenesis would be associated with the seminal vesicle agenesis (Hall and Oates, 1993). It is common to find bilateral absence of the seminal vesicles along with congenital

20. Cause of bleeding artery during PCNL when tract travels through COLUMN OF BERTIN

A. Interlobar

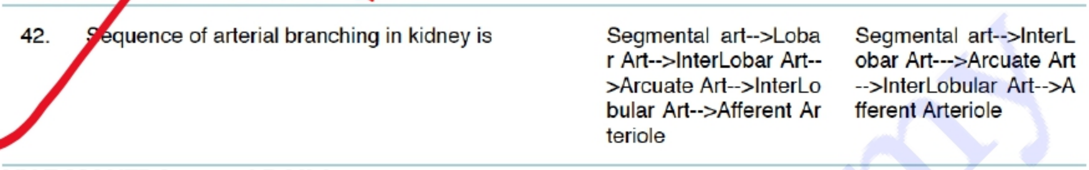
B. Interlobular

C. Arcuate

D. Segmental artery

Answer :A

VISE URO MOCK 3 Q 42

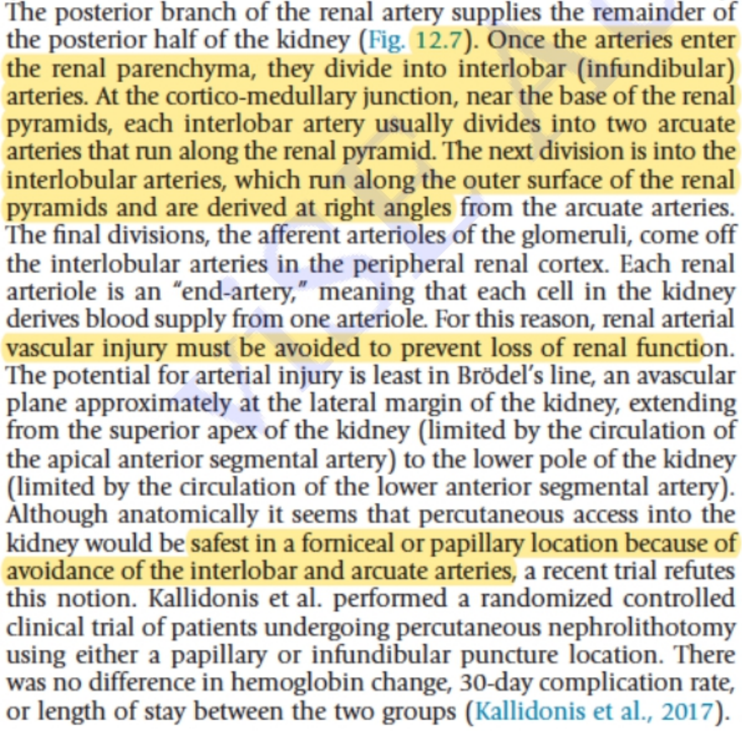


42.	Sequence of arterial branching in kidney is	Segmental art-->Lobar Art-->InterLobar Art-->Arcuate Art-->InterLobular Art-->Afferent Arteriole	Segmental art-->InterLobar Art--->Arcuate Art-->InterLobular Art-->Afferent Arteriole

VISE MANTRA -→ GRAILS-

Glomerulus
Radial/Interlobular
Arcuate
Interlobar
Lobar
Segmental

Explanation: Campbell Text Book Of Urology 12th Edition, Chapter.12, Page No. 162



The posterior branch of the renal artery supplies the remainder of the posterior half of the kidney (Fig. 12.7). Once the arteries enter the renal parenchyma, they divide into interlobar (infundibular) arteries. At the cortico-medullary junction, near the base of the renal pyramids, each interlobar artery usually divides into two arcuate arteries that run along the renal pyramid. The next division is into the interlobular arteries, which run along the outer surface of the renal pyramids and are derived at right angles from the arcuate arteries. The final divisions, the afferent arterioles of the glomeruli, come off the interlobular arteries in the peripheral renal cortex. Each renal arteriole is an "end-artery," meaning that each cell in the kidney derives blood supply from one arteriole. For this reason, renal arterial vascular injury must be avoided to prevent loss of renal function. The potential for arterial injury is least in Brödel's line, an avascular plane approximately at the lateral margin of the kidney, extending from the superior apex of the kidney (limited by the circulation of the apical anterior segmental artery) to the lower pole of the kidney (limited by the circulation of the lower anterior segmental artery). Although anatomically it seems that percutaneous access into the kidney would be safest in a forniceal or papillary location because of avoidance of the interlobar and arcuate arteries, a recent trial refutes this notion. Kallidonis et al. performed a randomized controlled clinical trial of patients undergoing percutaneous nephrolithotomy using either a papillary or infundibular puncture location. There was no difference in hemoglobin change, 30-day complication rate, or length of stay between the two groups (Kallidonis et al., 2017).

21. What percentage of VHL patient develops RCC

A.10%

B.30%

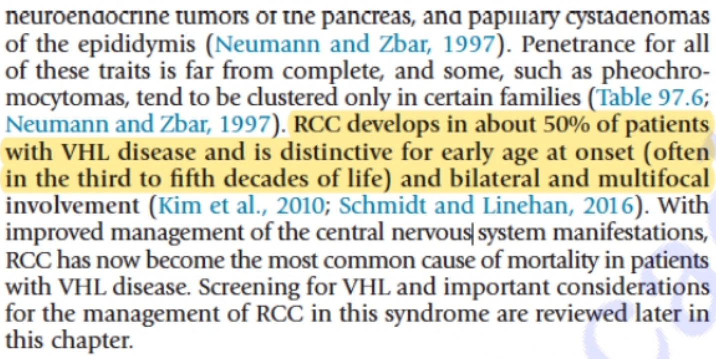
C.50%

D 70%

Answer : C

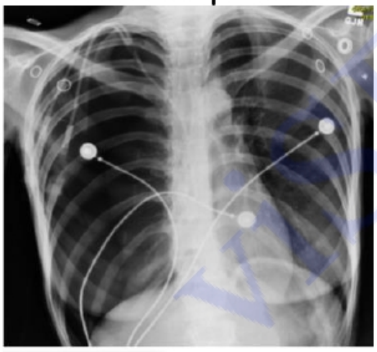
VISE URO ONCO LECTURE NOTES- RCC

Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No.97, Page No. 2141



neuroendocrine tumors of the pancreas, and papillary cystadenomas of the epididymis (Neumann and Zbar, 1997). Penetrance for all of these traits is far from complete, and some, such as pheochromocytomas, tend to be clustered only in certain families (Table 97.6; Neumann and Zbar, 1997). RCC develops in about 50% of patients with VHL disease and is distinctive for early age at onset (often in the third to fifth decades of life) and bilateral and multifocal involvement (Kim et al., 2010; Schmidt and Linehan, 2016). With improved management of the central nervous system manifestations, RCC has now become the most common cause of mortality in patients with VHL disease. Screening for VHL and important considerations for the management of RCC in this syndrome are reviewed later in this chapter.

22. The complication shown in the image is likely due to :



A. Prone position

B. Central venous catheter access related complication

C. PCNL complication

D. None of these

Answer : B

23. 60 year old gentleman has SERUM PSA is 5 and on TRUS BIOPSY GLEASON SCORE IS 6 with past h/o 3 times cardiac stenting. What is the best management plan for this patient:

A. Radical prostatectomy

B. Radical radiotherapy

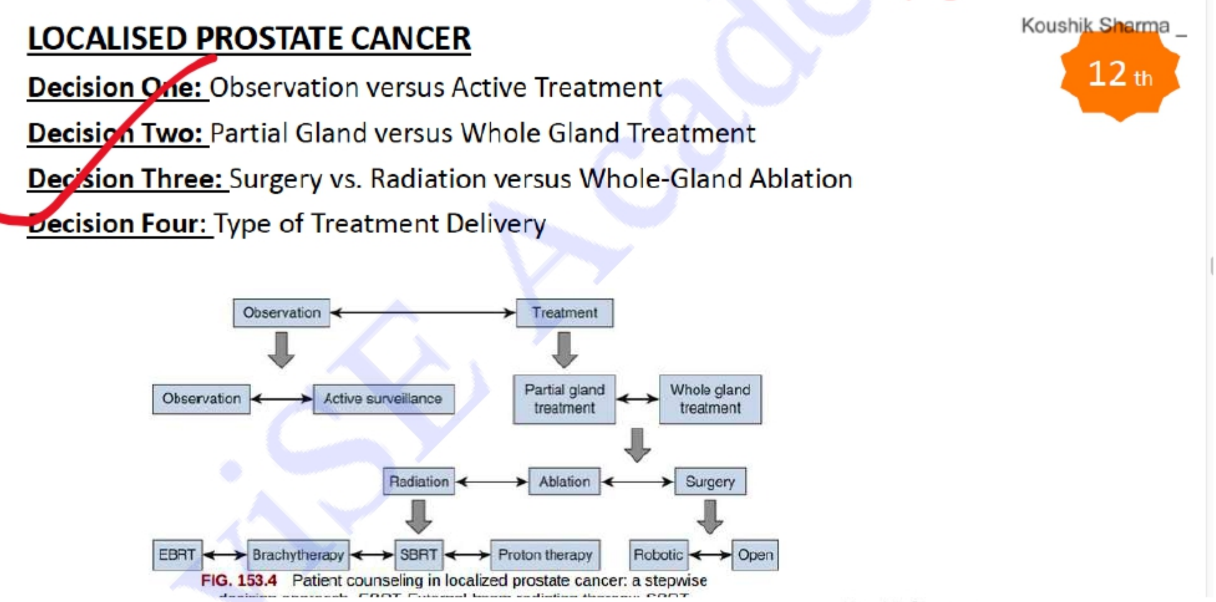
C. Active surveillance

D. Androgen ablation

Answer : C

Explanation:

VISE URO ONCO LECTURE NOTES- CA PROSTATE page 249/251



Koushik Sharma _

12 th

LOCALISED PROSTATE CANCER

Decision One: Observation versus Active Treatment

Decision Two: Partial Gland versus Whole Gland Treatment

Decision Three: Surgery vs. Radiation versus Whole-Gland Ablation

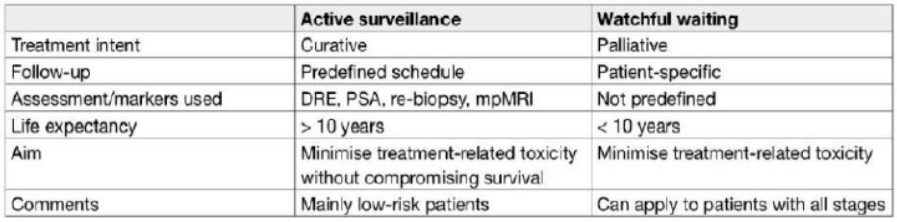
Decision Four: Type of Treatment Delivery

Observation
Treatment
Observation
Active surveillance
Partial gland treatment
Whole gland treatment
Radiation
Ablation
Surgery
EBRT
Brachytherapy
SBRT
Proton therapy
Robotic
Open

FIG. 153.4 Patient counseling in localized prostate cancer: a stepwise

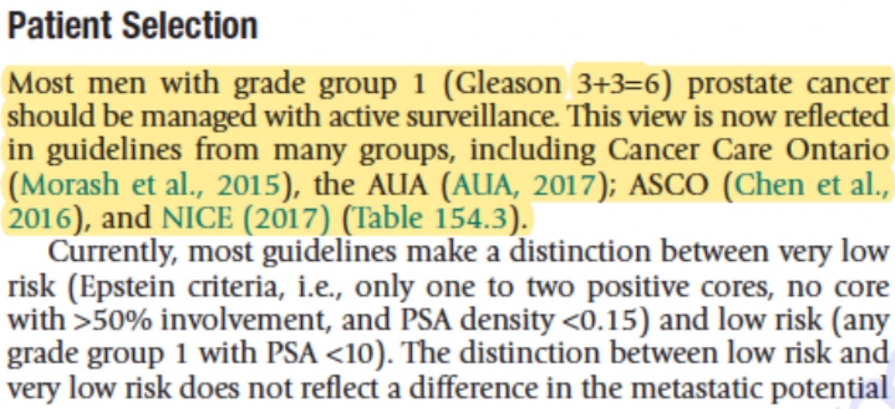
Koushik Sharma _

Table 6.1.1: Definitions of active surveillance and watchful waiting [384]



	Active surveillance	Watchful waiting
Treatment intent	Curative	Palliative
Follow-up	Predefined schedule	Patient-specific
Assessment/markers used	DRE, PSA, re-biopsy, mpMRI	Not predefined
Life expectancy	> 10 years	< 10 years
Aim	Minimise treatment-related toxicity without compromising survival	Minimise treatment-related toxicity
Comments	Mainly low-risk patients	Can apply to patients with all stages

Campbell Text Book Of Urology 12th Edition, Chapter No.154, Page No. 3540



Patient Selection

Most men with grade group 1 (Gleason 3+3=6) prostate cancer should be managed with active surveillance. This view is now reflected in guidelines from many groups, including Cancer Care Ontario (Morash et al., 2015), the AUA (AUA, 2017); ASCO (Chen et al., 2016), and NICE (2017) (Table 154.3).

Currently, most guidelines make a distinction between very low risk (Epstein criteria, i.e., only one to two positive cores, no core with >50% involvement, and PSA density <0.15) and low risk (any grade group 1 with PSA <10). The distinction between low risk and very low risk does not reflect a difference in the metastatic potential

24. 62year gentleman with dysuria, frequency,urgency two weeks duration. Symptoms not subsiding and he has tachycardia+ raised tlc. On pr he has a TENDER, BOGGY PROSTATE. The next best management plan is:

A.TRUS scan

B.MRI

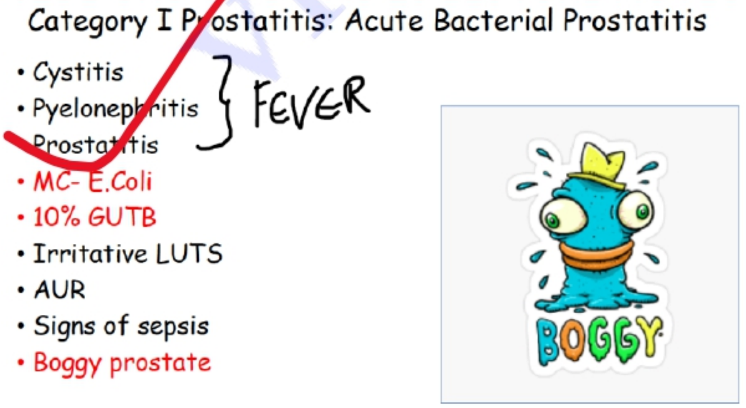
C.CHANGE ANTIBIOTICS

D. CT ABDOMEN AND PELVIS

Answer : D

Explanation:

VISE URO CPPS AND IC LECTURE NOTES



Category I Prostatitis: Acute Bacterial Prostatitis

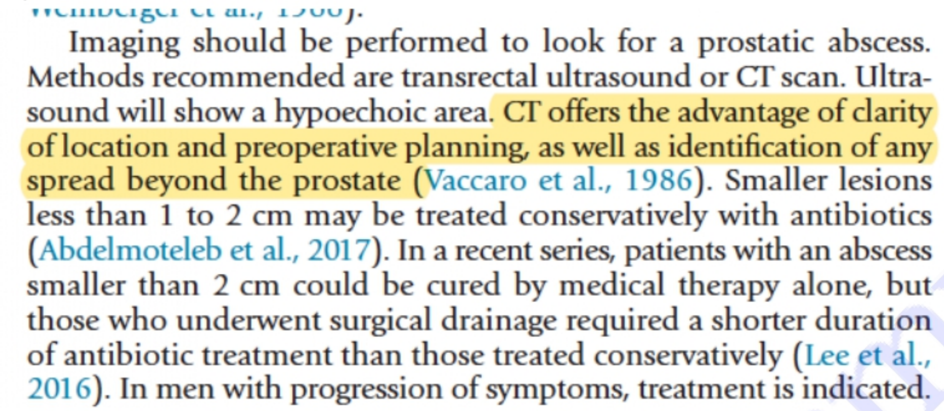
- Cystitis
- Pyelonephritis
- Prostatitis

} FEVER

- MC- E.Coli
- 10% GUTB
- Irritative LUTS
- AUR
- Signs of sepsis
- Boggy prostate

Campbell Text Book Of Urology 12th Edition, Chapter No.56, Page No. 1204

Failure to respond to therapy needs imaging for prostatic abscess evaluation



Imaging should be performed to look for a prostatic abscess. Methods recommended are transrectal ultrasound or CT scan. Ultrasound will show a hypoechoic area. CT offers the advantage of clarity of location and preoperative planning, as well as identification of any spread beyond the prostate (Vaccaro et al., 1986). Smaller lesions less than 1 to 2 cm may be treated conservatively with antibiotics (Abdelmoteleb et al., 2017). In a recent series, patients with an abscess smaller than 2 cm could be cured by medical therapy alone, but those who underwent surgical drainage required a shorter duration of antibiotic treatment than those treated conservatively (Lee et al., 2016). In men with progression of symptoms, treatment is indicated.

25. Prostate drains into which lymph node

A. Internal iliac and obturator

B. External iliac and obturator

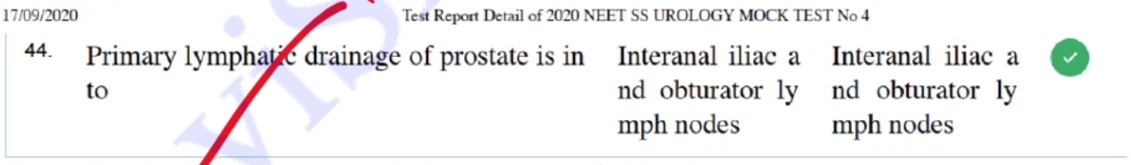
C. Common iliac nodes

D. Para aortic nodes

Answer : A

Explanation:

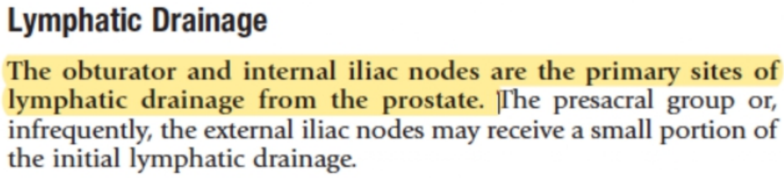
VISE URO MOCK 4 Q 44



17/09/2020 Test Report Detail of 2020 NEET SS UROLOGY MOCK TEST No 4

44.	Primary lymphatic drainage of prostate is in to	Interanal iliac and obturator lymph nodes	Interanal iliac and obturator lymph nodes	✓

Campbell Text Book Of Urology 12th Edition, Chapter No. 63 , Page No.1380



Lymphatic Drainage

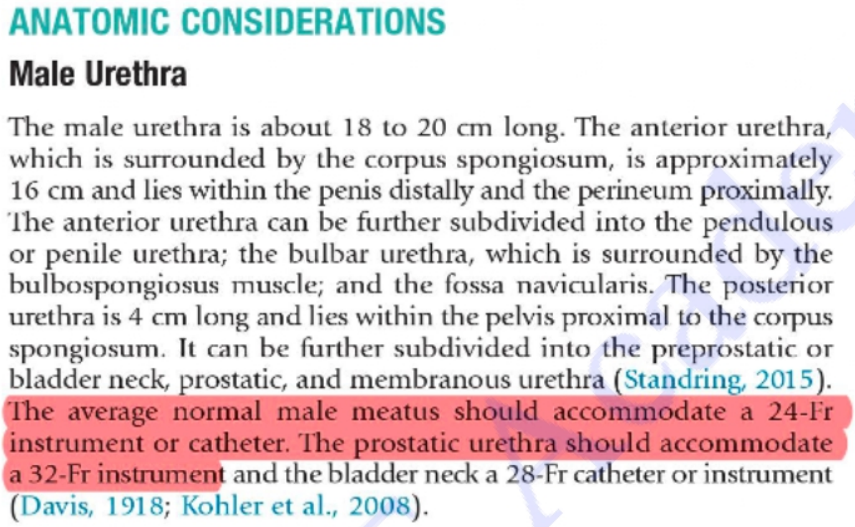
The obturator and internal iliac nodes are the primary sites of lymphatic drainage from the prostate. The presacral group or, infrequently, the external iliac nodes may receive a small portion of the initial lymphatic drainage.

26. Correct about MALE URETHRA

A. Bulbar urethra is narrowest and admits 24f catheter
B. Bladder neck is narrowest and admits 24f catheter
C. Meatus is narrowest and admits 24f catheter
D. Prostatic urethra is shortest and should allow 24f.

Answer : C

Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No.11, Page No.152



ANATOMIC CONSIDERATIONS

Male Urethra

The male urethra is about 18 to 20 cm long. The anterior urethra, which is surrounded by the corpus spongiosum, is approximately 16 cm and lies within the penis distally and the perineum proximally. The anterior urethra can be further subdivided into the pendulous or penile urethra; the bulbar urethra, which is surrounded by the bulbospongiosus muscle; and the fossa navicularis. The posterior urethra is 4 cm long and lies within the pelvis proximal to the corpus spongiosum. It can be further subdivided into the preprostatic or bladder neck, prostatic, and membranous urethra (Standring, 2015). The average normal male meatus should accommodate a 24-Fr instrument or catheter. The prostatic urethra should accommodate a 32-Fr instrument and the bladder neck a 28-Fr catheter or instrument (Davis, 1918; Kohler et al., 2008).

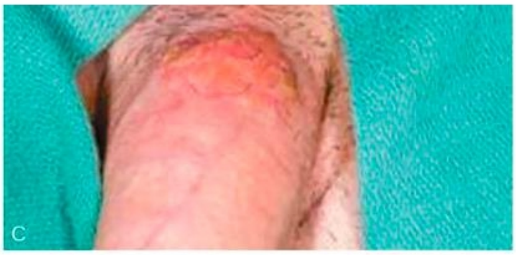
27. True about MALE URETHRA

A. Whole anterior urethra covered by penis
B. Pelvic trauma generally involve membranous urethra
C. BXO never involve navicular fossa
D. None of these

Answer : B

Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No.133 , Page No.3057

Pseudoepitheliomatous keratotic and micaceous balanitis (PKMB) is a rare lesion that manifests as a hyperkeratotic scaly, micaceous growth on the surface of the glans penis. Microscopic features of the tumor include marked hyperkeratosis and parakeratosis in addition to pseudo epitheliomatous hyperplasia. The differential diagnosis of these lesions includes verrucous carcinoma, squamous cell carcinoma, giant condyloma, penile horn, and keratoacanthoma (Das et al., 2014). PKMB occurs in four stages, including (1) initial plaque, (2) late tumor stage, (3) verrucous carcinoma, and (4) invasive squamous cell carcinoma (Krunic et al., 1996). Treatment is based upon stage at presentation and can include topical 5-flourouracil, surgical excision, laser ablation, or cryotherapy. However, PKMB tends to recur as a frank carcinoma when less invasive treatment occurs and therefore requires close follow-up and prompt excision (Gray and Ansell, 1990).



eFig. 79.1. (A) Cutaneous horn with underlying well-differentiated squamous cell carcinoma. (B) Buschke-Löwenstein tumor. (C) Bowen disease involving penile shaft skin.

Male Lichen Sclerosus (Balanitis Xerotica Obliterans)

Male lichen sclerosus (LS) (balanitis xerotica obliterans), a genital variation of lichen sclerosus et atrophicus, manifests as a whitish patch on the prepuce or glans, often involving the meatus and sometimes extending into the fossa navicularis. The lesions m be multiple and may assume a mosaic appearance. The meatus ma, appear white, indurated, and edematous. Glanular erosions, fissures, and meatal stenosis may occur. The disorder is most common in uncircumcised men and occurs most commonly in middle-aged

ANATOMIC CONSIDERATIONS

Male Urethra

The male urethra is about 18 to 20 cm long. The anterior urethra, which is surrounded by the corpus spongiosum, is approximately 16 cm and lies within the penis distally and the perineum proximally. The anterior urethra can be further subdivided into the pendulous or penile urethra; the bulbar urethra, which is surrounded by the bulbospongiosus muscle; and the fossa navicularis. The posterior urethra is 4 cm long and lies within the pelvis proximal to the corpus spongiosum. It can be further subdivided into the preprostatic or bladder neck, prostatic, and membranous urethra (Standring, 2015). The average normal male meatus should accommodate a 24-Fr instrument or catheter. The prostatic urethra should accommodate a 32-Fr instrument and the bladder neck a 28-Fr catheter or instrument (Davis, 1918; Kohler et al., 2008).

Posterior Urethral Injuries

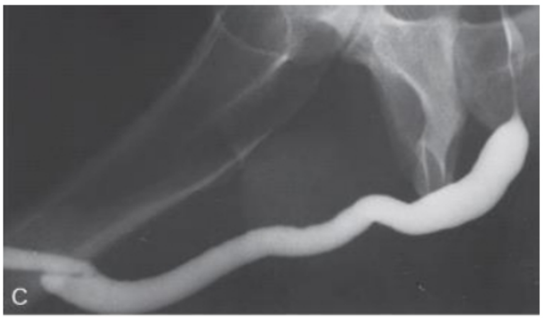
Etiology

Pelvic fracture urethral injury (PFUI) typically occurs in conjunction with multisystem trauma from motor vehicle accidents, falls, or industrial accidents. Fracture of the anterior pelvic ring or pubic diastasis is usually present when urethral disruption is encountered, and a greater degree of displacement has been correlated to a higher risk for urethral injury (Basta et al., 2007). **"Straddle fractures"** (eFig. 133.16) **involving all four pubic rami and fractures resulting in vertical and rotational pelvic instability are associated with the highest risk for urologic injury** (Brandes and Borelli, 2001; Koraitim, 1999; Mundy, 1996). Urethral injury has been reported to occur in approximately 10% of male patients and up to 6% of female patients with pelvic fractures (Black et al., 2006; Koraitim, 1999). Girls younger than 17 years of age have a higher risk for urethral injury compared with women, perhaps because of greater compressibility of the pelvic bones (Hemal et al., 1999).

Because the posterior urethra is densely adherent to the pubis via the urogenital diaphragm and the puboprostatic ligaments, the bulbomembranous junction is more vulnerable to injury during pelvic fracture than the prostatomembranous junction (Brandes

USE Academy

28. Identify the diagnosis from the image



A.NORMALRGU
B.BLADDERNECKOBSTRUCTION
C.PROXIMALBULBARSTRICTURE
D.MEATALSTENOSIS

Answer:A
Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No. 82 , Page No. 1816

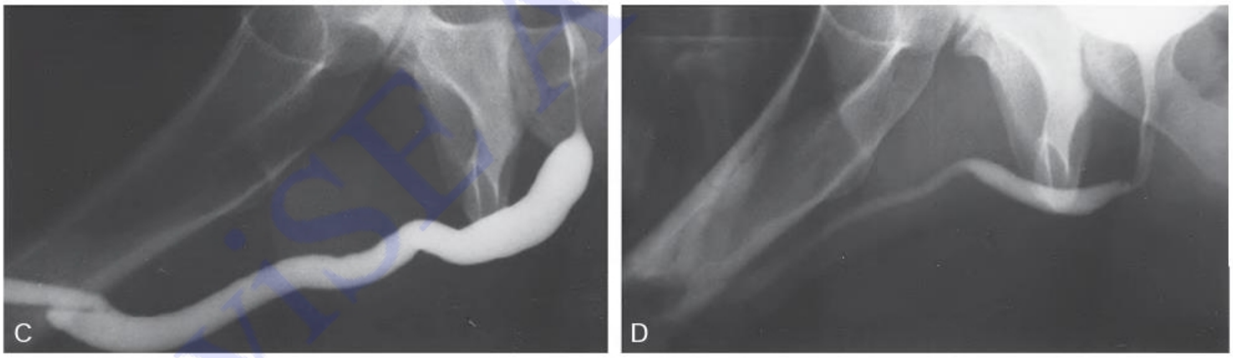
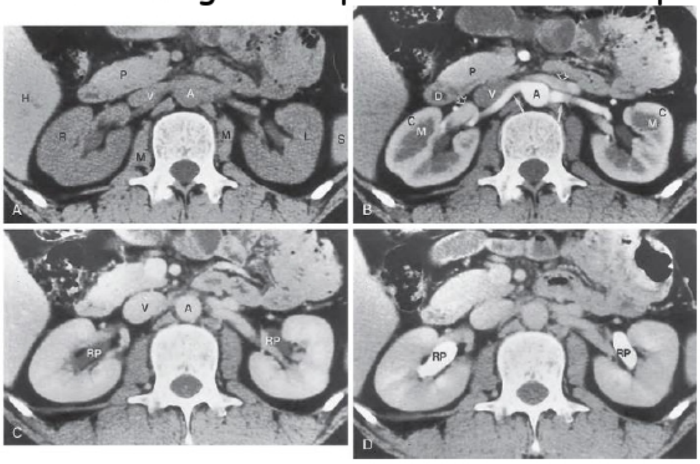


Fig. 82.16. (A) Representation of a dynamic retrograde urethrogram with the criteria of McCallum illustrated. (B) Representation of a dynamic voiding urethrogram with the criteria of McCallum illustrated. (C) Normal retrograde urethrogram. (D) Normal voiding urethrogram. (A and B, Modified from McCallum RW: The adult male urethra. *Radiol Clin North Am* 17:227–244, 1979.)

29.In The CECT AXIAL IMAGES shown below labelled (ABCD) which of the following correspond to cortical nephrogenic phase



P
H
V
A
R
M
M
L
S
A
P
D
V
A
C
M
C
M
B
V
A
RP
RP
C
RP
RP
D

A. Image A
B. Image B
C. Image C
D. Image D

Answer : B
Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No. 3 , Page No. 50

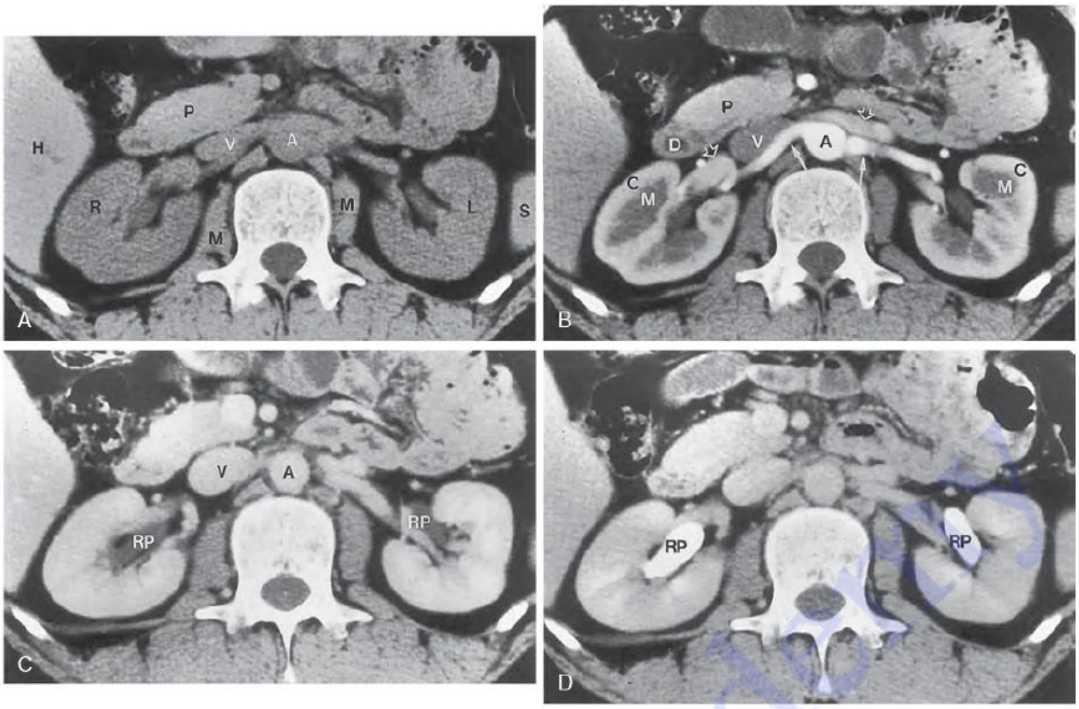


Fig. 3.19. Renal CT demonstrating normal nephrogenic progression. (A) Unenhanced CT scan obtained at the level of the renal hilum shows right *(R)* and left *(L)* kidneys of CT attenuation values slightly less than those of the liver *(H)* and pancreas *(P)*. *A,* Abdominal aorta; *M,* psoas muscle; *S,* spleen; *V,* inferior vena cava. (B) Enhanced CT scan obtained during a cortical nephrographic phase, generally 25 to 80 seconds after contrast medium injection, reveals increased enhancement of the renal cortex *(C)* relative to the medulla *(M)*. The main renal artery is indicated with *solid arrows* bilaterally. Main renal veins *(open arrows)* are less opacified with respect to the aorta *(A)* and arteries. *D,* Duodenum; *P,* pancreas; *V,* inferior vena cava. (C) CT scan obtained during the homogeneous nephrographic phase, generally between 85 and 120 seconds after contrast medium administration, reveals a homogeneous, uniform, increased attenuation of the renal parenchyma. The wall of the normal renal pelvis *(RP)* is paper thin or not visible on the CT scan. *A,* Abdominal aorta; *V,* inferior vena cava. (D) CT scan obtained during the excretory phase shows contrast medium in the RP bilaterally; this starts to appear approximately 3 minutes after contrast medium administration.

30. Medullary sponge kidney presentation which of the following is true -

A. Associated With Hypocalcaemia

B. Recurrent Uti Is Commonest Presentation

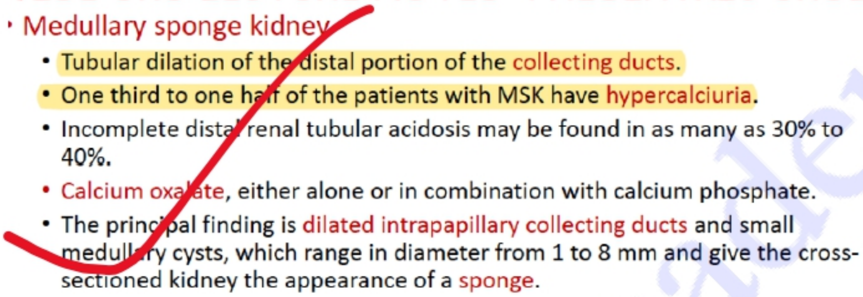
C. Renal Mass Is M/C Presentation

D. Ivu Is Superior To Ct In Making Diagnosis At Early Stage

Answer:D

Explanation:

VISE URO LECTURE NOTES- PAEDIATRIC UROLOGY-PAGE 73



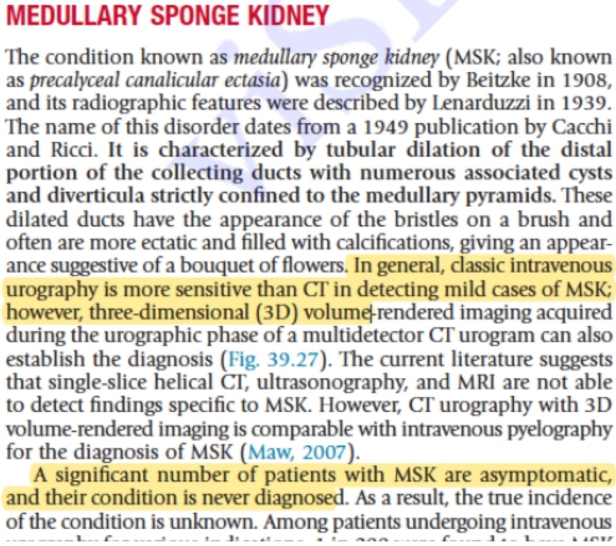
- Medullary sponge kidney
  - Tubular dilation of the distal portion of the collecting ducts.
  - One third to one half of the patients with MSK have hypercalciuria.
  - Incomplete distal renal tubular acidosis may be found in as many as 30% to 40%.
  - Calcium oxalate, either alone or in combination with calcium phosphate.
  - The principal finding is dilated intrapapillary collecting ducts and small medullary cysts, which range in diameter from 1 to 8 mm and give the cross-sectioned kidney the appearance of a sponge.

Campbell Text Book Of Urology 12th Edition, Chapter No. 39 , Page No. 771

Option A Is Wrong As Msk Is A/W Hypercalcemia

Option B Is Wrong As Most Of Msk Are Asymptomatic

Option C Is Wrong As Most Of Msk Are Asymptomatic



MEDULLARY SPONGE KIDNEY

The condition known as *medullary sponge kidney* (MSK; also known as *precalyceal canalicular ectasia*) was recognized by Beitzke in 1908, and its radiographic features were described by Lenarduzzi in 1939. The name of this disorder dates from a 1949 publication by Cacchi and Ricci. It is characterized by tubular dilation of the distal portion of the collecting ducts with numerous associated cysts and diverticula strictly confined to the medullary pyramids. These dilated ducts have the appearance of the bristles on a brush and often are more ectatic and filled with calcifications, giving an appearance suggestive of a bouquet of flowers. In general, classic intravenous urography is more sensitive than CT in detecting mild cases of MSK; however, three-dimensional (3D) volume-rendered imaging acquired during the urographic phase of a multidetector CT urogram can also establish the diagnosis (Fig. 39.27). The current literature suggests that single-slice helical CT, ultrasonography, and MRI are not able to detect findings specific to MSK. However, CT urography with 3D volume-rendered imaging is comparable with intravenous pyelography for the diagnosis of MSK (Maw, 2007).

A significant number of patients with MSK are asymptomatic, and their condition is never diagnosed. As a result, the true incidence of the condition is unknown. Among patients undergoing intravenous

31. T1A penile lesion with right side 1.5 cm inguinal node. The next line ofmanagement

A.DSNB

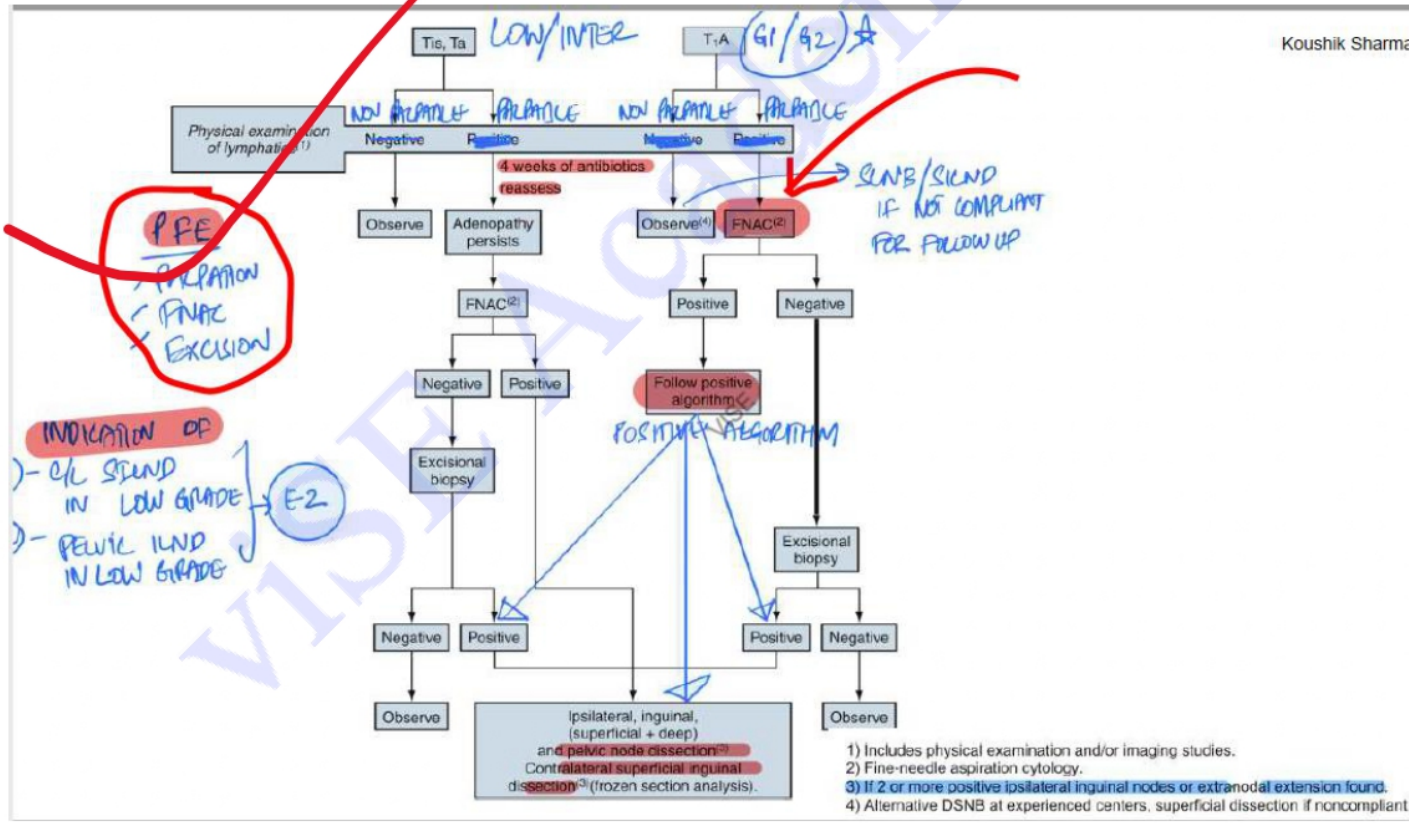
B.FNAC

C. Right Side Superficial, Deep And Pelvic Lymph Node Dissection And Left Side Superficial Inguinal Lymph Node Dissection

D. Right Side Superficial, Deep And Pelvic Lymph Node Dissection And Left Side Complete Modified Inguinal Lymph Node Dissection

Answer:B

Explanation: VISE URO LECTURE NOTES- CA PENIS- PAGE NO 129 – THE PFE MNEMONIC/VISE MANTRA


Tis, Ta
LOW/INTER
T1A
G1/G2
Koushik Sharma
Physical examination of lymphatics(1)
NON PALPABLE
PALPABLE
NON PALPABLE
PALPABLE
Negative
Positive
Negative
Positive
4 weeks of antibiotics reassess
SLNB/SILND IF NOT COMPLIANT FOR FOLLOW UP
Observe
Adenopathy persists
Observe(4)
FNAC(2)
PFE
PALPATION
FNAC
EXCISION
FNAC(2)
Positive
Negative
Negative
Positive
Follow positive algorithm
POSITIVE ALGORITHM
INDICATION OF
)- C/L SILND IN LOW GRADE
)- PELVIC ILND IN LOW GRADE
E-2
Excisional biopsy
Excisional biopsy
Negative
Positive
Positive
Negative
Observe
Ipsilateral, inguinal, (superficial + deep) and pelvic node dissection(3) Contralateral superficial inguinal dissection(3) (frozen section analysis).
Observe

1) Includes physical examination and/or imaging studies.
2) Fine-needle aspiration cytology.
3) If 2 or more positive ipsilateral inguinal nodes or extranodal extension found.
4) Alternative DSNB at experienced centers, superficial dissection if noncompliant

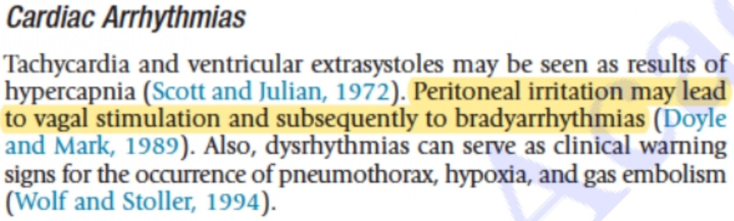
Campbell Text Book Of Urology 12th Edition, Chapter No. 79 , Page No. 1763

32. After Verres Needle Insertion And During Insufflation Patient Develops Bradycardia & Asystole. Next Step Is

A. Immediate Laparotomy
B. Deflate And Remove Gas Its Due To Peritoneal Stretching
C. Check Endotracheal Tube As It May Have Dislodged Due To Abdominal Distension
D. Coronary Vasodilators As Patient Is Suspected To Have Got Mi

Answer : B
Explanation:

VISE URO MOCK 2 Q NO 21 QUESTION ON complications in LAP
Campbell Text Book Of Urology 12th Edition, Chapter No.14 , Page No. 221



Cardiac Arrhythmias

Tachycardia and ventricular extrasystoles may be seen as results of hypercapnia (Scott and Julian, 1972). Peritoneal irritation may lead to vagal stimulation and subsequently to bradyarrhythmias (Doyle and Mark, 1989). Also, dysrhythmias can serve as clinical warning signs for the occurrence of pneumothorax, hypoxia, and gas embolism (Wolf and Stoller, 1994).

33. Patient Presented After 3 Months Of Abdominal Hysterectomy Presented With Continuous Dribbling Of Urine Per Vagina, She Also Have Normal Voiding Pattern Per Urethra. The Most Likely Cause Is

A. VVF
B. URETHRO-VAGINAL FISTULA
C. VVF IN AREA OF TRIGONE
D. URETERO VAGINAL FISTULA

Answer : D
Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No. 129 , Page No. 2946

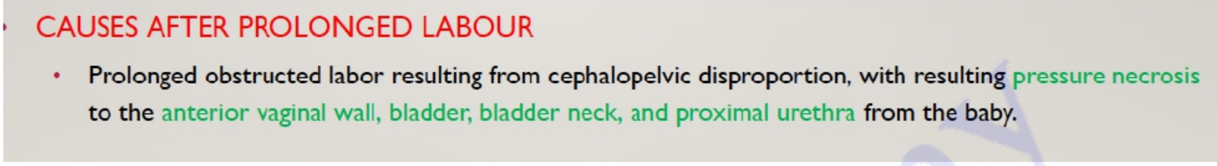
Vesicouterine fistulae are among the least common urogynecologic fistulae (Benchekroun et al., 1999; Tancer, 1986). However, the incidence of this condition is increasing in parallel with the rising numbers of low-segment cesarean sections being done worldwide (Kumar et al., 1988; Porcaro et al., 2002). **Cesarean section is by far the most common cause of this unusual fistula** (Tancer, 1986). Tancer related that of the 74 cases of vesicouterine fistulae reported from 1947 to 1986, 57 followed low-segment cesarean section, 7 followed vaginal operative delivery, and the remaining cases were related to a variety of disparate scenarios, including induced abortion, hysterectomy, and dilation and curettage (D&C). Jozwik et al. (1998) reported that 21 of 24 vesicouterine fistulae treated over a 12-year period occurred after cesarean section, the majority of which were repeat cesarean sections. Those undergoing vaginal birth after prior cesarean section (VBAC) are also at risk for vesicouterine fistula (Gil and Sultana, 2001). Vesicouterine fistulae may occur spontaneously as a result of a ruptured uterus during obstructed labor. In these cases, the posterior bladder wall may tear along the uterine rupture line creating the potential for a fistula. Bladder wall invasion by chorionic villi penetrating beyond the uterine serosa, placenta percreta, may also create a vesicouterine fistula (Krysiewicz et al., 1988). A foreign body such as an intrauterine device (IUD) (Schwartzwald et al., 1986), uterine artery embolization (Sultana et al., 2002), brachytherapy (Memon et al., 1998), traumatic bladder catheterization (Futter and Baker, 1995), Meyer-Rokitansky syndrome (Okusanya and Garba, 2010), and endometrial ablation (Rooney and Cholhan, 2010) have been reported to cause vesicouterine fistula. **In most cases, simultaneous injury to the bladder and uterus is the inciting event.** An unrecognized and unrepaired (occult) bladder injury, or incorporation of a portion of the bladder during closure of the uterus during any number of operations, may result in a vesicouterine fistula. **Anatomically, the most common location of the fistula is along the posterior bladder wall in the midline, or from the genital side, just cephalad to the internal cervical os.**

Unlike other types of urogynecologic fistulae, vesicouterine fistulae may or may not manifest with constant urinary incontinence because of the sphincter-like activity of the cervix; the

The most common presenting symptom is the onset of constant urinary incontinence 1 to 4 weeks after surgery (Mandal et al., 1990). This may have been preceded by several days of flank or abdominal pain, nausea, and low-grade fever, presumably as a result of urinoma and/or obstruction of the kidney (Lee et al., 1988). Flank pain will often be masked in the postoperative period because of the use of postoperative narcotic analgesics. **Of importance, and in direct contrast to VVF, in the setting of continuous urine leakage from a ureterovaginal fistula, patients will continue to report normal voiding habits because bladder filling is maintained from the contralateral, presumably undamaged, upper urinary tract.**

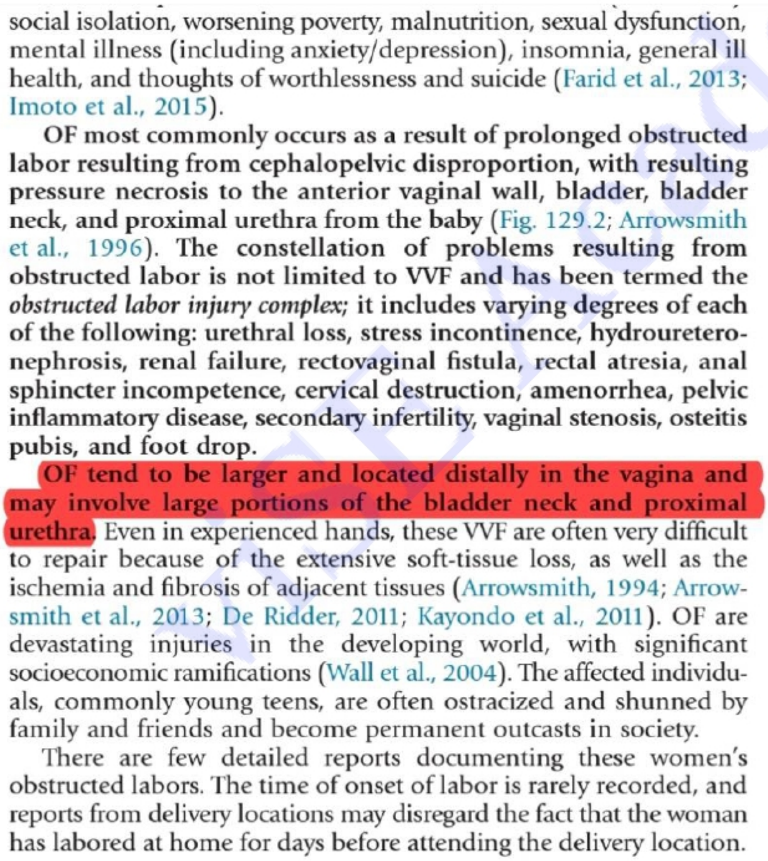
Prevention of this type of fistula is usually done by preventive

34. Most Likely Cause Of Infra Trigonal Vvf
A. Vagina Hysterectomy
B. Abdominal Hysterectomy
C. Obstructed Labor
D. Radiation
Answer : C
Explanation: VISE URO LECTURE NOTES- FEMALE UROLOGY-202



- CAUSES AFTER PROLONGED LABOUR
  - Prolonged obstructed labor resulting from cephalopelvic disproportion, with resulting pressure necrosis to the anterior vaginal wall, bladder, bladder neck, and proximal urethra from the baby.

Campbell Text Book Of Urology 12th Edition, Chapter No. 129 , Page No. 2925



social isolation, worsening poverty, malnutrition, sexual dysfunction, mental illness (including anxiety/depression), insomnia, general ill health, and thoughts of worthlessness and suicide (Farid et al., 2013; Imoto et al., 2015).

OF most commonly occurs as a result of prolonged obstructed labor resulting from cephalopelvic disproportion, with resulting pressure necrosis to the anterior vaginal wall, bladder, bladder neck, and proximal urethra from the baby (Fig. 129.2; Arrowsmith et al., 1996). **The constellation of problems resulting from obstructed labor is not limited to VVF and has been termed the *obstructed labor injury complex;* it includes varying degrees of each of the following: urethral loss, stress incontinence, hydroureteronephrosis, renal failure, rectovaginal fistula, rectal atresia, anal sphincter incompetence, cervical destruction, amenorrhea, pelvic inflammatory disease, secondary infertility, vaginal stenosis, osteitis pubis, and foot drop.**

OF tend to be larger and located distally in the vagina and may involve large portions of the bladder neck and proximal urethra. Even in experienced hands, these VVF are often very difficult to repair because of the extensive soft-tissue loss, as well as the ischemia and fibrosis of adjacent tissues (Arrowsmith, 1994; Arrowsmith et al., 2013; De Ridder, 2011; Kayondo et al., 2011). OF are devastating injuries in the developing world, with significant socioeconomic ramifications (Wall et al., 2004). The affected individuals, commonly young teens, are often ostracized and shunned by family and friends and become permanent outcasts in society.

There are few detailed reports documenting these women's obstructed labors. The time of onset of labor is rarely recorded, and reports from delivery locations may disregard the fact that the woman has labored at home for days before attending the delivery location.

35. Which Among The Following Is Not Used In Management Of BCG Sepsis:

A. Isoniazid

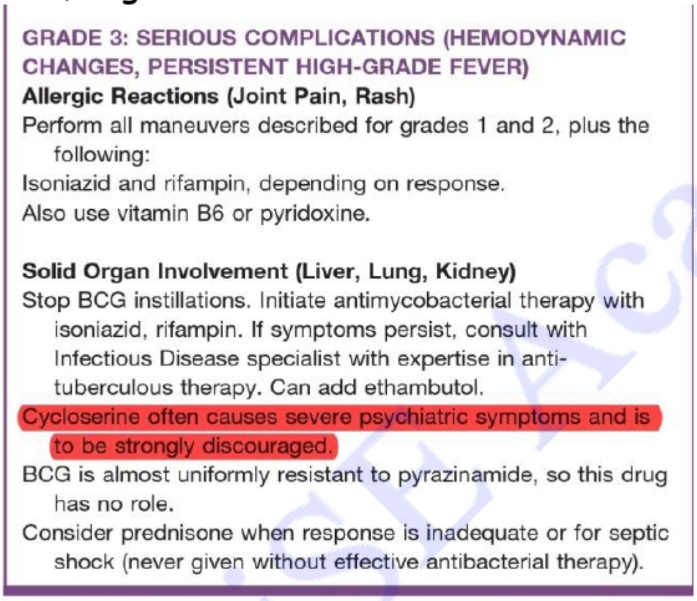
B. Rifampicin

C. Cycloserine

D. Steriods If Septic Shock

Answer : C

Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No. 136, Page No. 3102



GRADE 3: SERIOUS COMPLICATIONS (HEMODYNAMIC CHANGES, PERSISTENT HIGH-GRADE FEVER)

Allergic Reactions (Joint Pain, Rash)

Perform all maneuvers described for grades 1 and 2, plus the following:

Isoniazid and rifampin, depending on response.

Also use vitamin B6 or pyridoxine.

Solid Organ Involvement (Liver, Lung, Kidney)

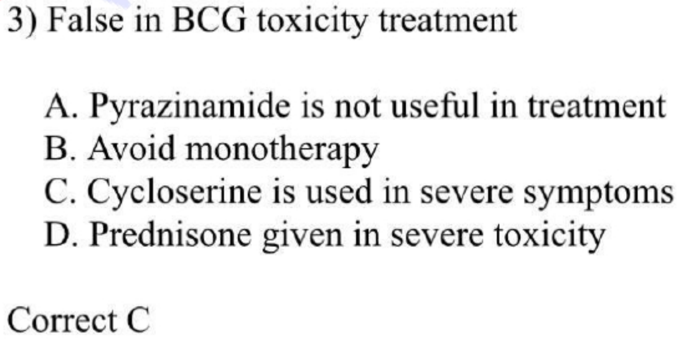
Stop BCG instillations. Initiate antimycobacterial therapy with isoniazid, rifampin. If symptoms persist, consult with Infectious Disease specialist with expertise in anti-tuberculous therapy. Can add ethambutol.

Cycloserine often causes severe psychiatric symptoms and is to be strongly discouraged.

BCG is almost uniformly resistant to pyrazinamide, so this drug has no role.

Consider prednisone when response is inadequate or for septic shock (never given without effective antibacterial therapy).

VISE 6PM MCQ SESSIONS -21



3) False in BCG toxicity treatment

A. Pyrazinamide is not useful in treatment

B. Avoid monotherapy

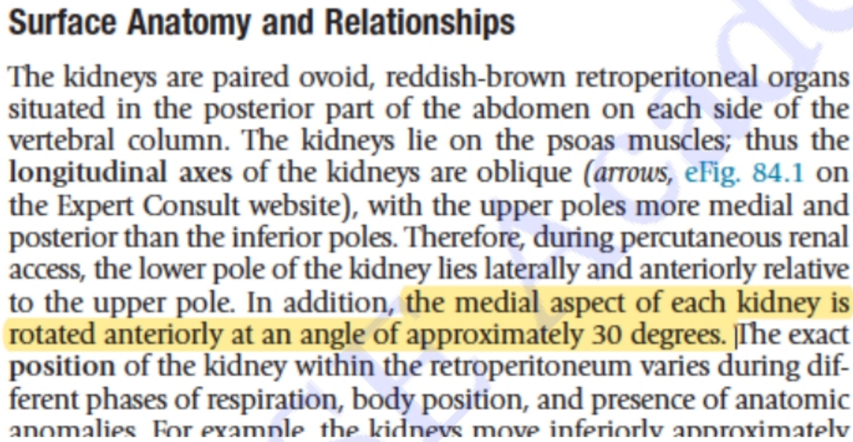
C. Cycloserine is used in severe symptoms

D. Prednisone given in severe toxicity

Correct C

36. Regarding Renal Anatomy which of following is True
A. Apposition To Colon More On Left Side Upper Pole
B. Kidney 30 Degree Off Frontal Plane And Lateral Surface Is Posterior To Medial
C. Kidney 30 Degree Off Vertical Plane And Lower Pole Medial In Comparison To Lateral Pole
D. Kidney 30 Degree Off From Frontal Plane Lower Pole Is Posterior To Upper Pole

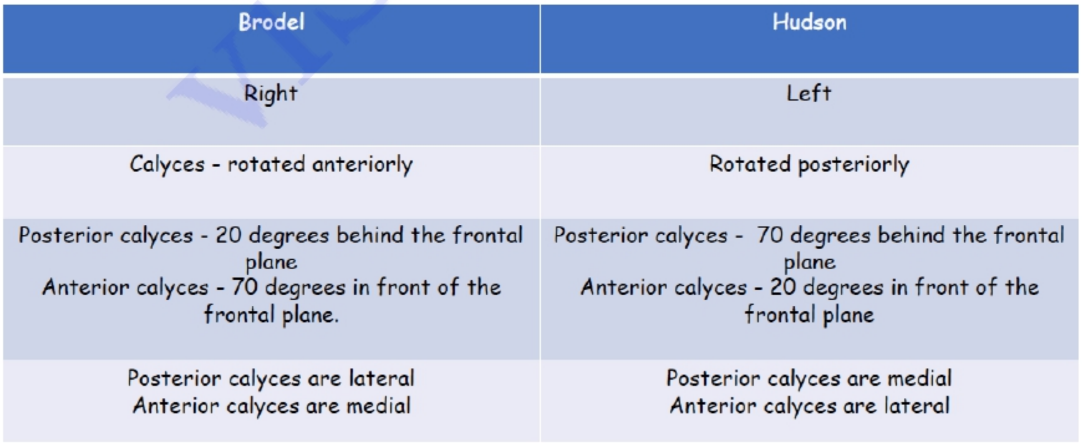
Answer : B
Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No. 84 , Page No. 1865



Surface Anatomy and Relationships

The kidneys are paired ovoid, reddish-brown retroperitoneal organs situated in the posterior part of the abdomen on each side of the vertebral column. The kidneys lie on the psoas muscles; thus the longitudinal axes of the kidneys are oblique (*arrows*, eFig. 84.1 on the Expert Consult website), with the upper poles more medial and posterior than the inferior poles. Therefore, during percutaneous renal access, the lower pole of the kidney lies laterally and anteriorly relative to the upper pole. In addition, the medial aspect of each kidney is rotated anteriorly at an angle of approximately 30 degrees. The exact position of the kidney within the retroperitoneum varies during different phases of respiration, body position, and presence of anatomic anomalies. For example, the kidneys move inferiorly approximately

VISE URO LECTURE NOTES- UROBASICS



Brodel	Hudson
Right	Left
Calyces - rotated anteriorly	Rotated posteriorly
Posterior calyces - 20 degrees behind the frontal plane Anterior calyces - 70 degrees in front of the frontal plane.	Posterior calyces - 70 degrees behind the frontal plane Anterior calyces - 20 degrees in front of the frontal plane
Posterior calyces are lateral Anterior calyces are medial	Posterior calyces are medial Anterior calyces are lateral

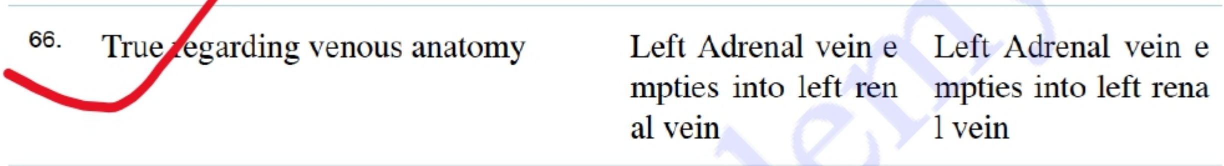
37. Left Varicocele More Common Because Left Testicular Vein Enters At Straight Angle Into --

A. Renal Vein
B. Ivc
C. Adrenal Vein
D. IMV

Answer : A

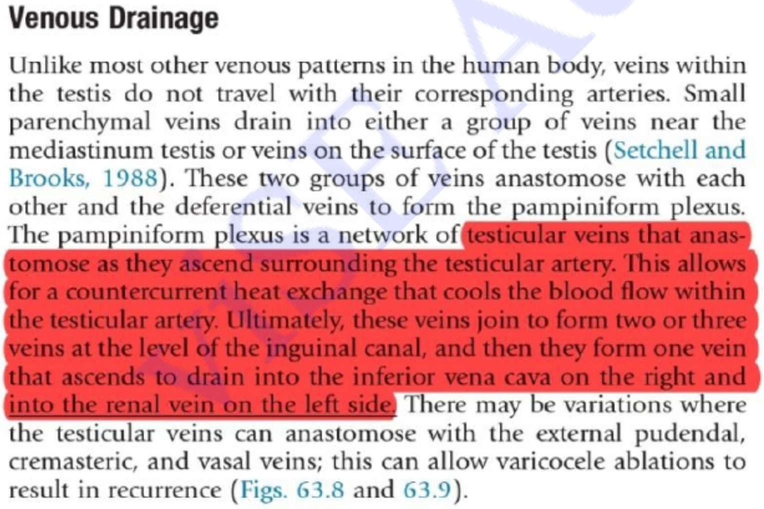
Explanation:

VISE URO MOCK 2 Q NO 66



66.	True regarding venous anatomy	Left Adrenal vein empties into left renal vein	Left Adrenal vein empties into left renal vein

Campbell Text Book Of Urology 12th Edition, Chapter No. 63 , Page No. 1372



Venous Drainage

Unlike most other venous patterns in the human body, veins within the testis do not travel with their corresponding arteries. Small parenchymal veins drain into either a group of veins near the mediastinum testis or veins on the surface of the testis (Setchell and Brooks, 1988). These two groups of veins anastomose with each other and the deferential veins to form the pampiniform plexus. The pampiniform plexus is a network of testicular veins that anastomose as they ascend surrounding the testicular artery. This allows for a countercurrent heat exchange that cools the blood flow within the testicular artery. Ultimately, these veins join to form two or three veins at the level of the inguinal canal, and then they form one vein that ascends to drain into the inferior vena cava on the right and into the renal vein on the left side. There may be variations where the testicular veins can anastomose with the external pudendal, cremasteric, and vasal veins; this can allow varicocele ablations to result in recurrence (Figs. 63.8 and 63.9).

38.Feature Of Organic ED In Contrast To Psychiatric Erectile Dysfunction All Except
A. Sudden Onset
B. Incremental Progression
C. Not Situational
D. Waking Erection Is Absent
Answer : A
Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No. 69 , Page No. 1518

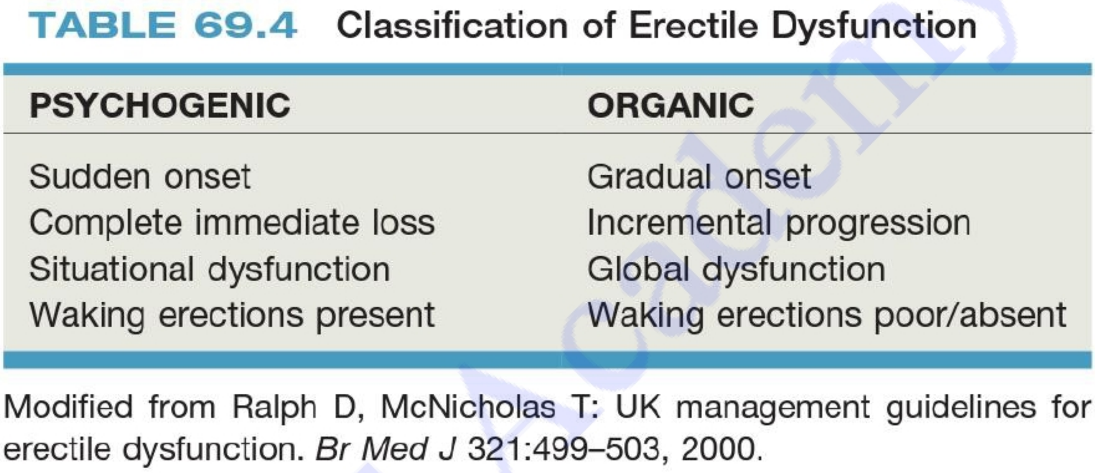


TABLE 69.4 Classification of Erectile Dysfunction

PSYCHOGENIC	ORGANIC
Sudden onset	Gradual onset
Complete immediate loss	Incremental progression
Situational dysfunction	Global dysfunction
Waking erections present	Waking erections poor/absent

Modified from Ralph D, McNicholas T: UK management guidelines for erectile dysfunction. *Br Med J* 321:499–503, 2000.

39.In a patient Absent Cremastic reflex the Nerve likely injured is?

A. GFN

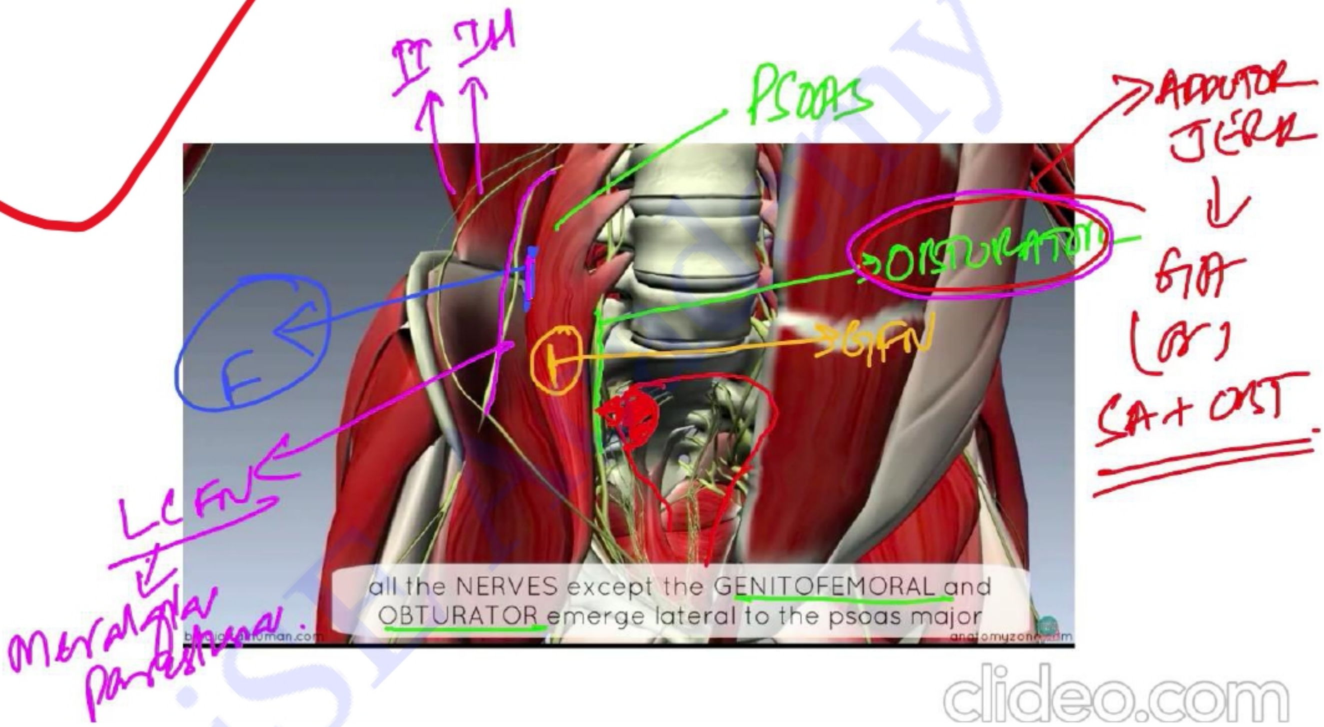
B. Ilioinguinal Nerve

C. Iliohypogastric Nerve

D. Obturator nerve

Answer : A

Explanation: SCREEN SHOT FROM VISE URO LECTURE VIDEOS ON NERVE INJURIES IN UROLOGY



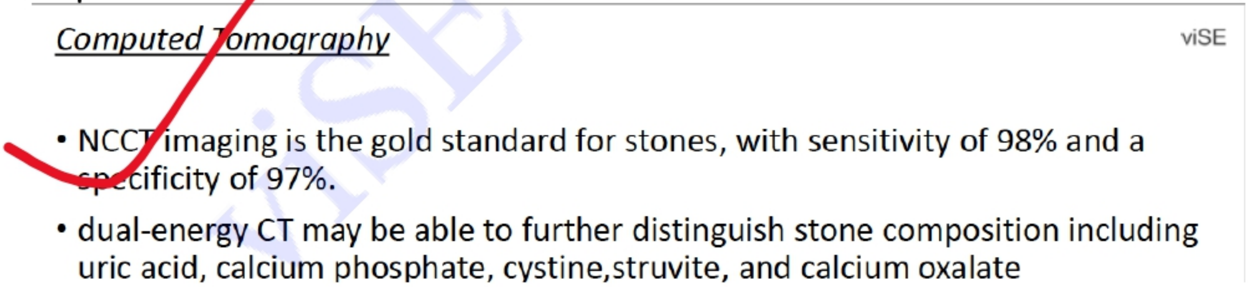
all the NERVES except the GENITOFEMORAL and OBTURATOR emerge lateral to the psoas major

II IH
PSOAS
>ADDUTOR JERK
↓
GA
(or)
SA + OBT
OBTURATOR
GFN
F
I
LCFN
↓
Meralgia paresthesia
biodigitalhuman.com
anatomyzone.com
clideo.com

40. Choose false option related to circumcision:
A. Child with UTI circumcision should be done
B. Circumcision can be done distal but should be avoided in proximal hypospadias
C. Circumcision dec the chance of HIV
D. Minor wound infection after circumcision can be managed conservatively
Answer : B

41. 5yr old child with history of lithuria and USG shows mild pelvicalyceal dilatation. Now c/o pain in left flank pain. What is the best to establish diagnosis
A.NCCT which is more sensitive for his history
B. MRI more to delineate soft tissues to avoid contrast exposure in him
C. CECT
D. None of the above

Answer : A
Explanation: VISE URO LECTURE NOTES- STONE DISEASE-PAGE 77



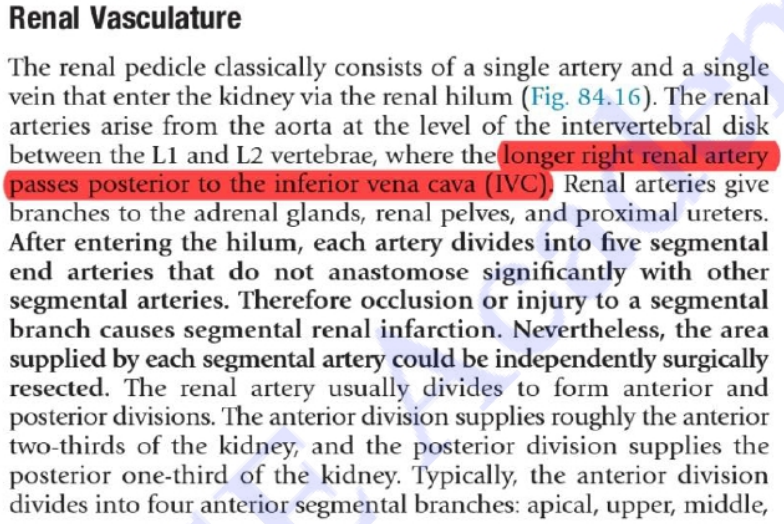
Computed Tomography

- NCCT imaging is the gold standard for stones, with sensitivity of 98% and a specificity of 97%.
- dual-energy CT may be able to further distinguish stone composition including uric acid, calcium phosphate, cystine,struvite, and calcium oxalate

Campbell text book of urology 12th edition, Chapter no. , Page no.

42. True About Renal Artery
A. Post. Segmental Artery Divide At Hilum
B. Accessory Renal Artery Mostly Supply Upper Pole
C. Apical Is Supplied By Posterior Seg Artery
D. Right Renal Artery Posterior To IVC

Answer : D
Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No.84 , Page No. 1869



Renal Vasculature

The renal pedicle classically consists of a single artery and a single vein that enter the kidney via the renal hilum (Fig. 84.16). The renal arteries arise from the aorta at the level of the intervertebral disk between the L1 and L2 vertebrae, where the longer right renal artery passes posterior to the inferior vena cava (IVC). Renal arteries give branches to the adrenal glands, renal pelves, and proximal ureters. **After entering the hilum, each artery divides into five segmental end arteries that do not anastomose significantly with other segmental arteries. Therefore occlusion or injury to a segmental branch causes segmental renal infarction. Nevertheless, the area supplied by each segmental artery could be independently surgically resected.** The renal artery usually divides to form anterior and posterior divisions. The anterior division supplies roughly the anterior two-thirds of the kidney, and the posterior division supplies the posterior one-third of the kidney. Typically, the anterior division divides into four anterior segmental branches: apical, upper, middle, 43.In A Patient With B/L Ureteric Stones, IVP Is Done And Patient Develops Sudden Flank Pain After The Procedure And Usg Showed Pericalyceal Fluid. The Likely Cause And Management

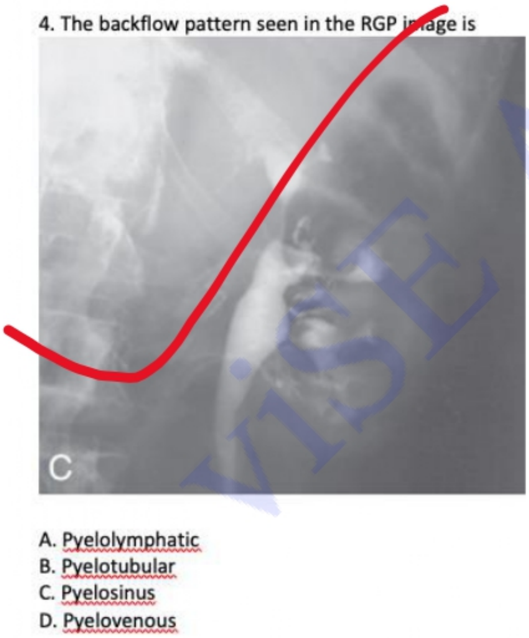
A. Pyelovenous Obstruction
B. Fornicial Rupture And Conservative Treatment
C. Pyelolymphatic Leak
D. Ureteropelvic Rupture

Answer: B

Explanation: types of backflows – Given twice in Mock tests

VISE URO MOCK 5 Q 4. Image based question on various types of backflows

VISE URO MOCK 2 Q 85

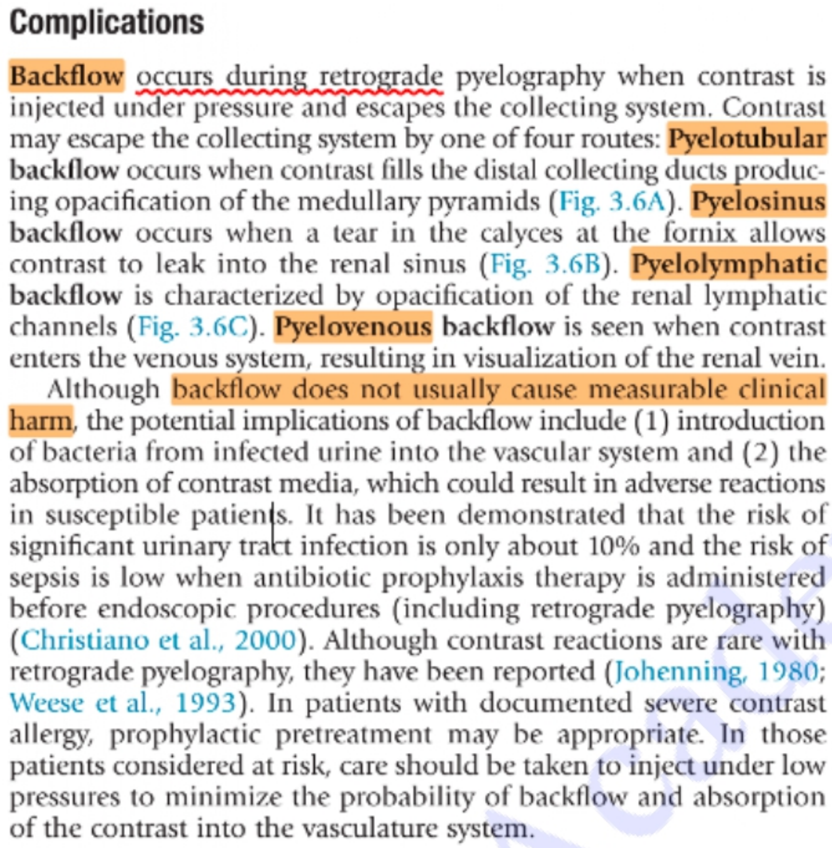


4. The backflow pattern seen in the RGP image is

A. Pyelolymphatic
B. Pyelotubular
C. Pyelosinus
D. Pyelovenous

A And C Wont Cause “Clinical Picture” As Described

B Is Much More Common In The Given Scenario Than D.



Complications

Backflow occurs during retrograde pyelography when contrast is injected under pressure and escapes the collecting system. Contrast may escape the collecting system by one of four routes: **Pyelotubular backflow** occurs when contrast fills the distal collecting ducts producing opacification of the medullary pyramids (Fig. 3.6A). **Pyelosinus backflow** occurs when a tear in the calyces at the fornix allows contrast to leak into the renal sinus (Fig. 3.6B). **Pyelolymphatic backflow** is characterized by opacification of the renal lymphatic channels (Fig. 3.6C). **Pyelovenous backflow** is seen when contrast enters the venous system, resulting in visualization of the renal vein.

Although backflow does not usually cause measurable clinical harm, the potential implications of backflow include (1) introduction of bacteria from infected urine into the vascular system and (2) the absorption of contrast media, which could result in adverse reactions in susceptible patients. It has been demonstrated that the risk of significant urinary tract infection is only about 10% and the risk of sepsis is low when antibiotic prophylaxis therapy is administered before endoscopic procedures (including retrograde pyelography) (Christiano et al., 2000). Although contrast reactions are rare with retrograde pyelography, they have been reported (Johenning, 1980; Weese et al., 1993). In patients with documented severe contrast allergy, prophylactic pretreatment may be appropriate. In those patients considered at risk, care should be taken to inject under low pressures to minimize the probability of backflow and absorption of the contrast into the vasculature system.

44. Patient with gunshot wound on right upper flank and back shows fat necrosis and bile, what is next best step

A. Kocherisation

B. Whipple

C. UGI Endoscopy

D.None Of These

Answer: A

Explanation:

45. 50 year old male patient with bph with 2 episodes of gross hematuria but no difficulties with passing urine, no evidence of hematuria on evaluation next management is

A. Angioembolization of internal iliac artery

B. 5 alpha reductase inhibitors

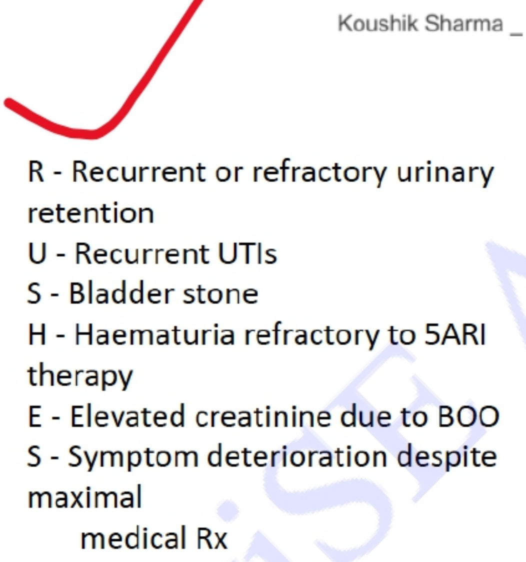
C. TURP

D. TRUS BIOPSY

Answer: B

Explanation: VISE URO LECTURE NOTES-BPH-149- Basic uro notes-382

RUSHES MNEMONIC/VISE MANTRA



Koushik Sharma _

R - Recurrent or refractory urinary retention

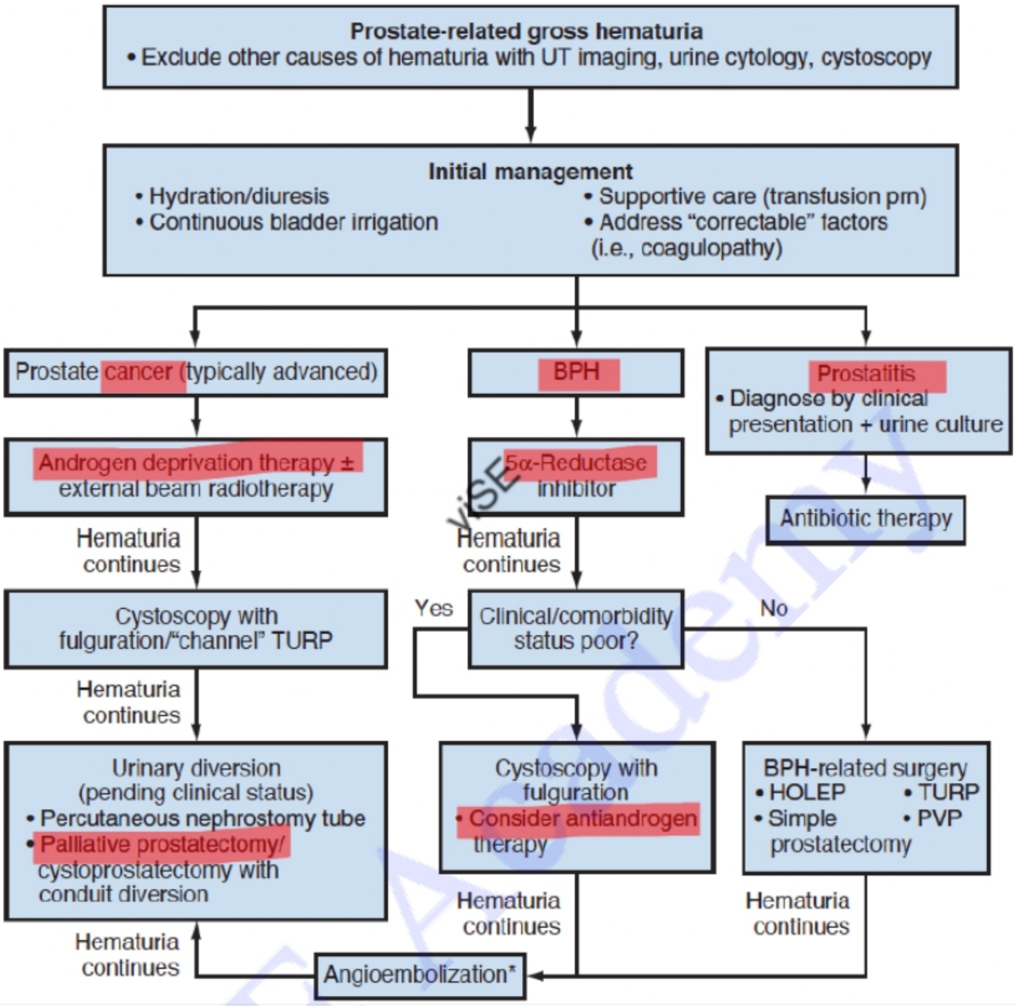
U - Recurrent UTIs

S - Bladder stone

H - Haematuria refractory to 5ARI therapy

E - Elevated creatinine due to BOO

S - Symptom deterioration despite maximal medical Rx


Prostate-related gross hematuria
• Exclude other causes of hematuria with UT imaging, urine cytology, cystoscopy
Initial management
• Hydration/diuresis
• Continuous bladder irrigation
• Supportive care (transfusion prn)
• Address "correctable" factors (i.e., coagulopathy)
Prostate cancer (typically advanced)
BPH
Prostatitis
• Diagnose by clinical presentation + urine culture
Androgen deprivation therapy ± external beam radiotherapy
5α-Reductase inhibitor
Antibiotic therapy
Hematuria continues
Hematuria continues
Cystoscopy with fulguration/"channel" TURP
Yes
Clinical/comorbidity status poor?
No
Hematuria continues
Urinary diversion (pending clinical status)
• Percutaneous nephrostomy tube
• Palliative prostatectomy/ cystoprostatectomy with conduit diversion
Cystoscopy with fulguration
• Consider antiandrogen therapy
BPH-related surgery
• HOLEP
• TURP
• Simple prostatectomy
• PVP
Hematuria continues
Hematuria continues
Hematuria continues
Angioembolization*

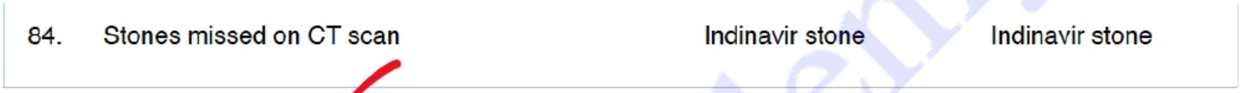
Campbell Text Book Of Urology 12th Edition, Chapter No. 146, Page No. 3807

Refractory HAEMATURIA to 5 alpha-reductase inhibitors is an indication for TURP. But here the patient first should be attempted with 5ARI before going to TURP.

46. Drug causing stone-
A. Indinavir
B. Lamivudine
C. Cephalosporins
D. None of these

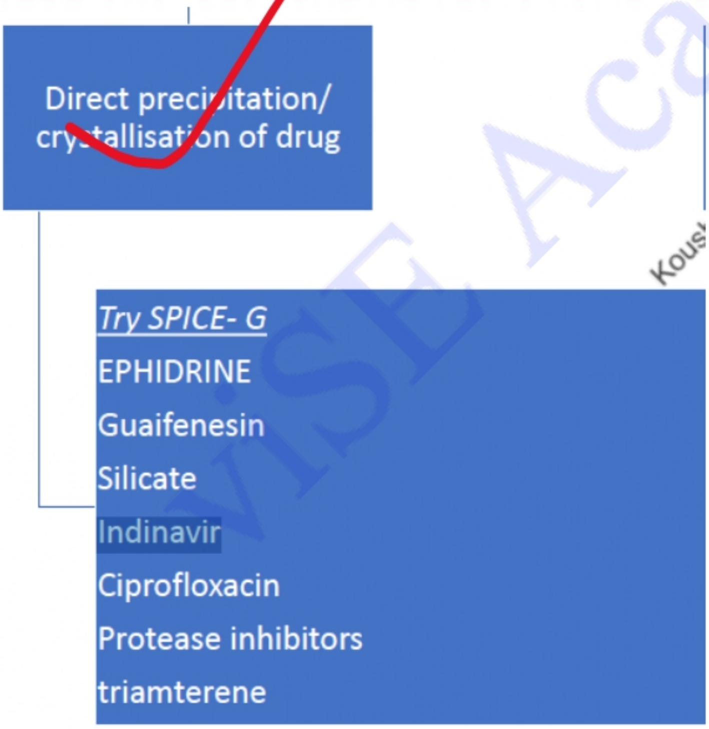
Answer : A
Explanation:

VISE URO MOCK 3 Q NO 84



84.	Stones missed on CT scan	Indinavir stone	Indinavir stone

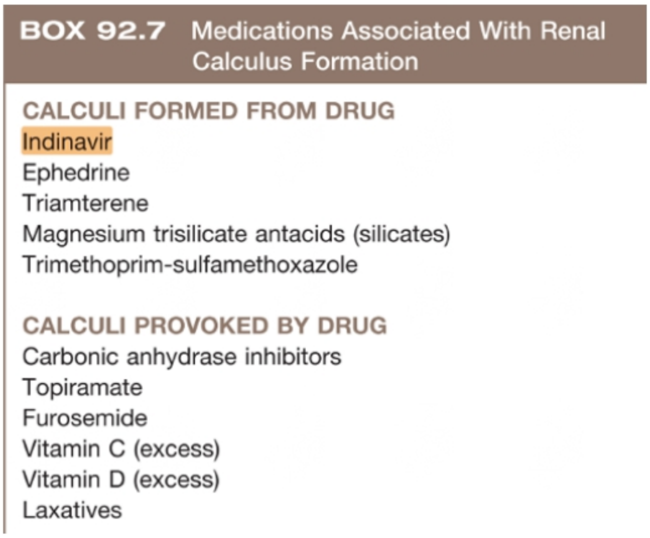
VISE URO LECTURE NOTES-STONE- 71- Try-SPICE-G MNEMONIC



Direct precipitation/ crystallisation of drug

Try SPICE- G
EPHIDRINE
Guaifenesin
Silicate
Indinavir
Ciprofloxacin
Protease inhibitors
triamterene

Campbell Text Book Of Urology 12th Edition, Chapter No. 92, Page No. 2065

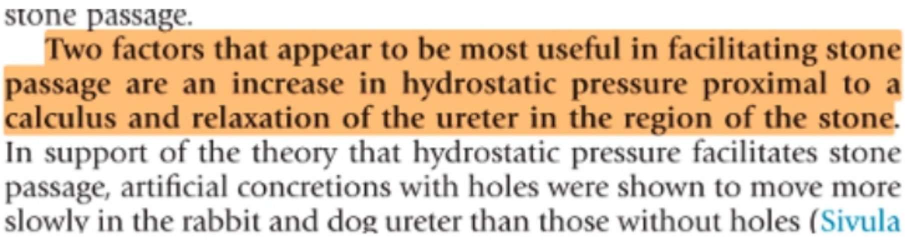


BOX 92.7 Medications Associated With Renal Calculus Formation

CALCULI FORMED FROM DRUG
Indinavir
Ephedrine
Triamterene
Magnesium trisilicate antacids (silicates)
Trimethoprim-sulfamethoxazole

CALCULI PROVOKED BY DRUG
Carbonic anhydrase inhibitors
Topiramate
Furosemide
Vitamin C (excess)
Vitamin D (excess)
Laxatives

47. Factors that facilitate ureteral stone passage include:
A. Increased hydrostatic pressures proximal to the calculus and relaxation of the ureter in the region of the stone.
B. Increased hydrostatic pressures proximal to the calculus and contraction of the ureter in the region of the stone.
C. Decreased hydrostatic pressures proximal to the calculus and relaxation of the ureter in the region of the stone.
D. Decreased hydrostatic pressures proximal to the calculus and contraction of the ureter in the region of the stone.
Answer: A
Explanation: campbell text book of urology 12th edition, chapter no. 87, page no. 1193
This question is DIRECT PICK UP FROM CAMPBELL BOARD REVIEW (chapter 85, question no 22)



stone passage.

Two factors that appear to be most useful in facilitating stone passage are an increase in hydrostatic pressure proximal to a calculus and relaxation of the ureter in the region of the stone. In support of the theory that hydrostatic pressure facilitates stone passage, artificial concretions with holes were shown to move more slowly in the rabbit and dog ureter than those without holes (Sivula

48. AKI occurs after _____days of contrast administration?

A. 6 hrs

B. 2-3 days

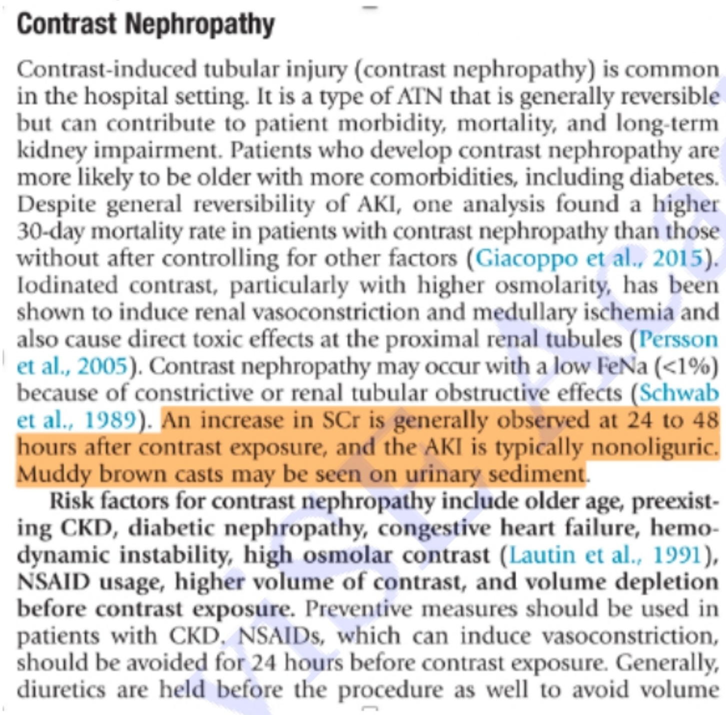
C. 48 hrs

D. 2 weeks

Answer: C

Explanation:

Campbell Text Book Of Urology 12th Edition, Chapter No. 3/87, Page No. 32;



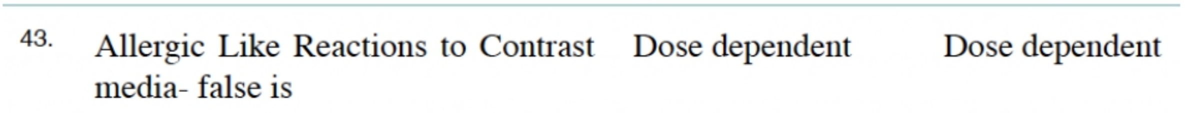
Contrast Nephropathy

Contrast-induced tubular injury (contrast nephropathy) is common in the hospital setting. It is a type of ATN that is generally reversible but can contribute to patient morbidity, mortality, and long-term kidney impairment. Patients who develop contrast nephropathy are more likely to be older with more comorbidities, including diabetes. Despite general reversibility of AKI, one analysis found a higher 30-day mortality rate in patients with contrast nephropathy than those without after controlling for other factors (Giacoppo et al., 2015). Iodinated contrast, particularly with higher osmolarity, has been shown to induce renal vasoconstriction and medullary ischemia and also cause direct toxic effects at the proximal renal tubules (Persson et al., 2005). Contrast nephropathy may occur with a low FeNa (<1%) because of constrictive or renal tubular obstructive effects (Schwab et al., 1989). An increase in SCr is generally observed at 24 to 48 hours after contrast exposure, and the AKI is typically nonoliguric. Muddy brown casts may be seen on urinary sediment.

Risk factors for contrast nephropathy include older age, preexisting CKD, diabetic nephropathy, congestive heart failure, hemodynamic instability, high osmolar contrast (Lautin et al., 1991), NSAID usage, higher volume of contrast, and volume depletion before contrast exposure. Preventive measures should be used in patients with CKD. NSAIDs, which can induce vasoconstriction, should be avoided for 24 hours before contrast exposure. Generally, diuretics are held before the procedure as well to avoid volume

VISE URO MOCK 2 Q NO 43 on contrast reactions

VISE URO MOCK 5 Q NO 42 on contrast reactions

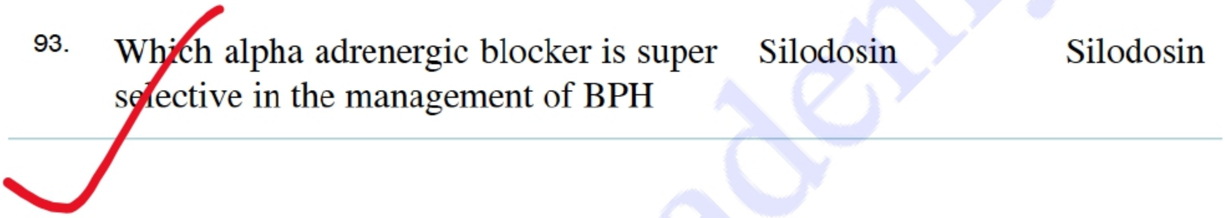


43.	Allergic Like Reactions to Contrast media- false is	Dose dependent	Dose dependent

49. Least selective alpha blocker?
A. Phenoxybenzamine
B. Indoramine
C. Naftopidil
D. Doxazosin

Answer: A
Explanation:

VISE URO MOCK 3 Q 93 on SUPERSELECTIVE alpha blocker



93.	Which alpha adrenergic blocker is super selective in the management of BPH	Silodosin	Silodosin

Campbell Text Book Of Urology 12th Edition, Chapter No. 145, Page No. 3356

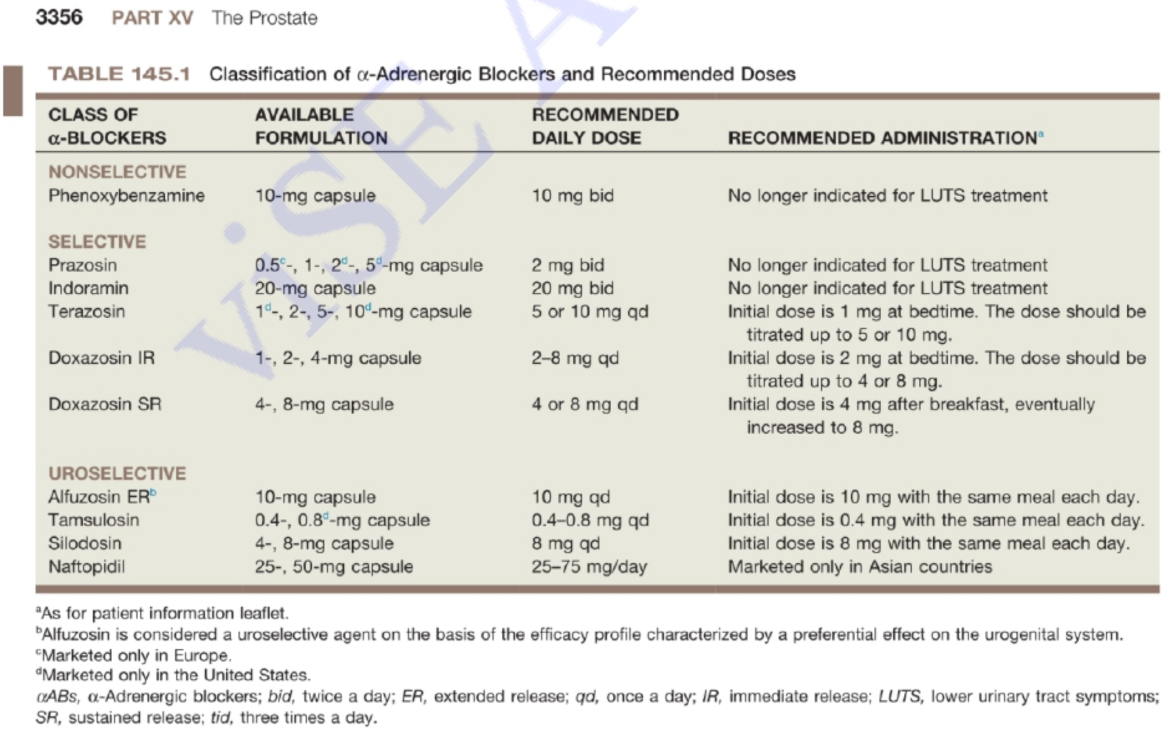


TABLE 145.1 Classification of α-Adrenergic Blockers and Recommended Doses

CLASS OF α-BLOCKERS	AVAILABLE FORMULATION	RECOMMENDED DAILY DOSE	RECOMMENDED ADMINISTRATION[a]
NONSELECTIVE			
Phenoxybenzamine	10-mg capsule	10 mg bid	No longer indicated for LUTS treatment
SELECTIVE			
Prazosin	0.5[c]-, 1-, 2[c]-, 5[d]-mg capsule	2 mg bid	No longer indicated for LUTS treatment
Indoramin	20-mg capsule	20 mg bid	No longer indicated for LUTS treatment
Terazosin	1[d]-, 2-, 5-, 10[d]-mg capsule	5 or 10 mg qd	Initial dose is 1 mg at bedtime. The dose should be titrated up to 5 or 10 mg.
Doxazosin IR	1-, 2-, 4-mg capsule	2–8 mg qd	Initial dose is 2 mg at bedtime. The dose should be titrated up to 4 or 8 mg.
Doxazosin SR	4-, 8-mg capsule	4 or 8 mg qd	Initial dose is 4 mg after breakfast, eventually increased to 8 mg.
UROSELECTIVE			
Alfuzosin ER[b]	10-mg capsule	10 mg qd	Initial dose is 10 mg with the same meal each day.
Tamsulosin	0.4-, 0.8[d]-mg capsule	0.4–0.8 mg qd	Initial dose is 0.4 mg with the same meal each day.
Silodosin	4-, 8-mg capsule	8 mg qd	Initial dose is 8 mg with the same meal each day.
Naftopidil	25-, 50-mg capsule	25–75 mg/day	Marketed only in Asian countries

[a] As for patient information leaflet.
[b] Alfuzosin is considered a uroselective agent on the basis of the efficacy profile characterized by a preferential effect on the urogenital system.
[c] Marketed only in Europe.
[d] Marketed only in the United States.
αABs, α-Adrenergic blockers; *bid,* twice a day; *ER,* extended release; *qd,* once a day; *IR,* immediate release; *LUTS,* lower urinary tract symptoms; *SR,* sustained release; *tid,* three times a day.

50. 50 years old lady with right loin pain, CT abdomen 8 cm mass in mid-pole right kidney with No other symptoms. Chest x ray normal. What is the next best step.

A. Radical nephrectomy as no other work up necessary
B. Palliative chemo
C. Partial + tyrosine kinase inhibitors
D. Pet CT for metastases

Answer: A

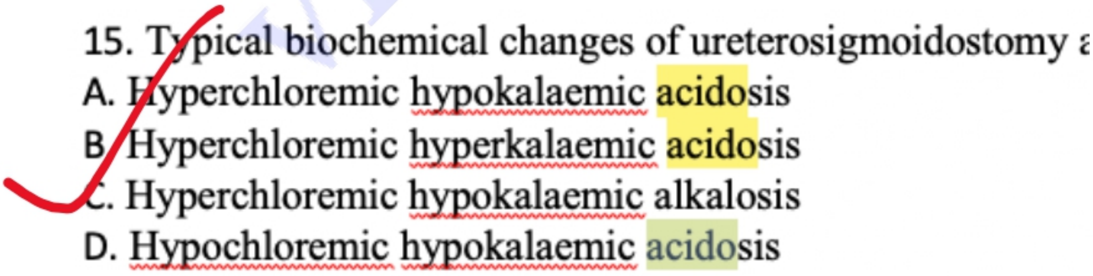
Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No. , Page No.

51. Jejunal intestinal diversion which electrolyte abnormality is seen?

A. Hyperkalemia
B. Hypokalemia
C. Hypercalcemia
D. Hyperchloremia

Answer : A

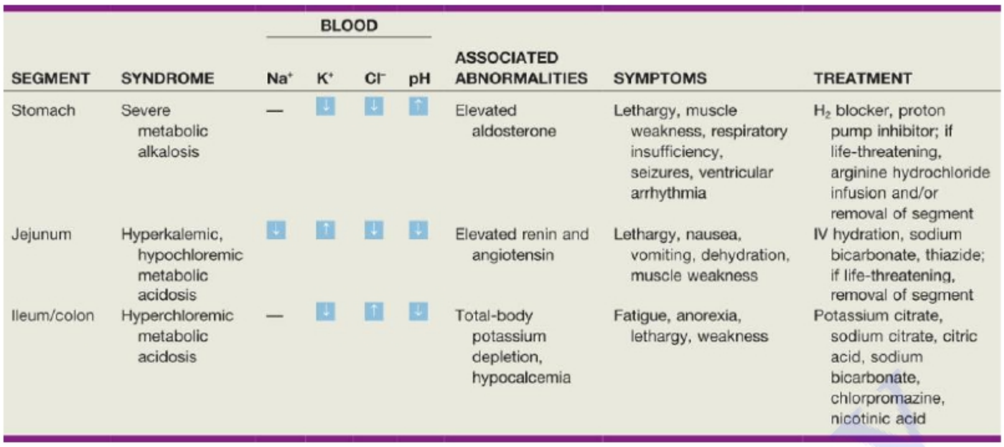
VISE URO MOCK 3 Q NO 15 ON ELECTROLYTE ABNORMALITIES
VISE URO LECTURE NOTES- BOWEL SEGMENTS- VISE MANTRA- JUMPING UP POTASSIUM (JK)



15. Typical biochemical changes of ureterosigmoidostomy

A. Hyperchloremic hypokalaemic acidosis
B. Hyperchloremic hyperkalaemic acidosis
C. Hyperchloremic hypokalaemic alkalosis
D. Hypochloremic hypokalaemic acidosis

Explanation: Campbell Text Book Of Urology 12th Edition, Chapter No. 139, Page No. 3199



SEGMENT	SYNDROME	BLOOD Na⁺	 K⁺	 Cl⁻	 pH	ASSOCIATED ABNORMALITIES	SYMPTOMS	TREATMENT
Stomach	Severe metabolic alkalosis	—	↓	↓	↑	Elevated aldosterone	Lethargy, muscle weakness, respiratory insufficiency, seizures, ventricular arrhythmia	H_2 blocker, proton pump inhibitor; if life-threatening, arginine hydrochloride infusion and/or removal of segment
Jejunum	Hyperkalemic, hypochloremic metabolic acidosis	↓	↑	↓	↓	Elevated renin and angiotensin	Lethargy, nausea, vomiting, dehydration, muscle weakness	IV hydration, sodium bicarbonate, thiazide; if life-threatening, removal of segment
Ileum/colon	Hyperchloremic metabolic acidosis	—	↓	↑	↓	Total-body potassium depletion, hypocalcemia	Fatigue, anorexia, lethargy, weakness	Potassium citrate, sodium citrate, citric acid, sodium bicarbonate, chlorpromazine, nicotinic acid

52. Elderly male with diabetes with upper pole 6.8 cm mass. Optimum management

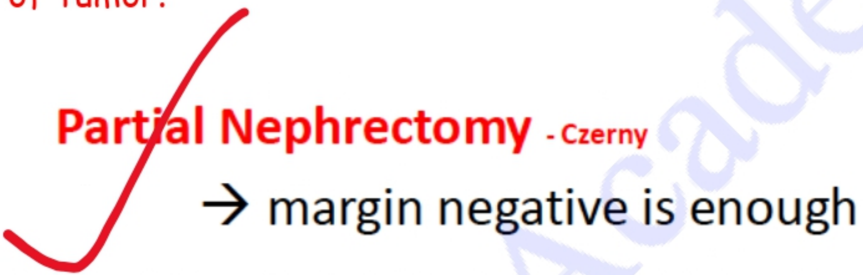
A. Neoadjuvant TKI for tumour downsizing followed by partial nephrectomy
B. Radical nephrectomy
C. Partial nephrectomy with follow up
D. Radiofrequency ablation

Answer: C

Explanation: VISE URO LECTURE NOTES-RCC-PAGE 84

VISE URO MOCK 3 Q 65 (question on Feasibility of PN/RENAL score)

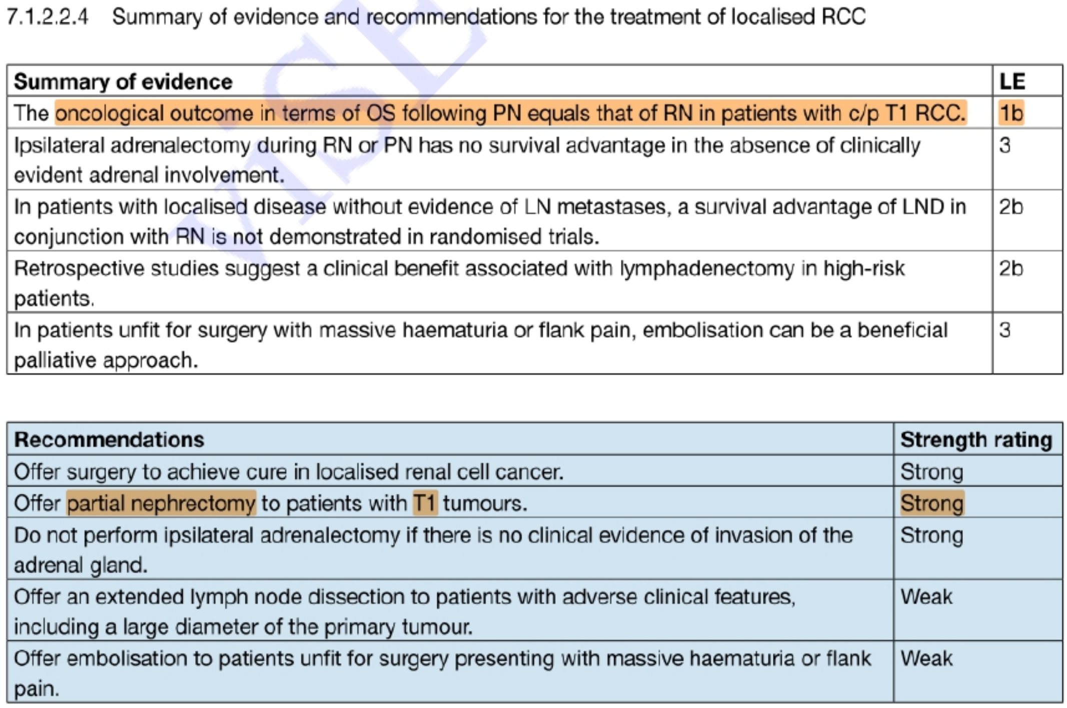
Ability to achieve Negative Margin is the requirement and not the Size of tumor.



Partial Nephrectomy - Czerny

→ margin negative is enough

Campbell Text Book Of Urology 12th Edition, Chapter No. 97, Page No. 2163

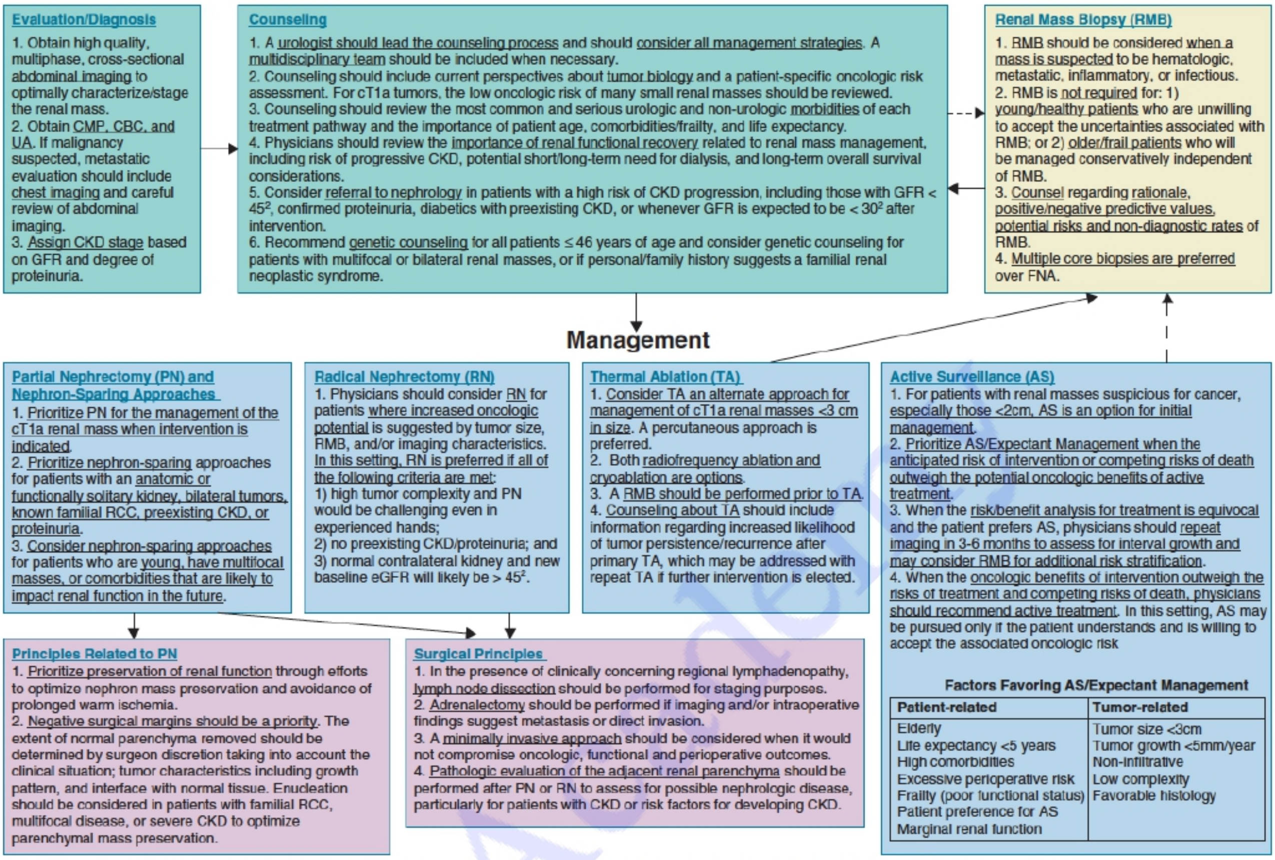


7.1.2.2.4 Summary of evidence and recommendations for the treatment of localised RCC

Summary of evidence	LE
The oncological outcome in terms of OS following PN equals that of RN in patients with c/p T1 RCC.	1b
Ipsilateral adrenalectomy during RN or PN has no survival advantage in the absence of clinically evident adrenal involvement.	3
In patients with localised disease without evidence of LN metastases, a survival advantage of LND in conjunction with RN is not demonstrated in randomised trials.	2b
Retrospective studies suggest a clinical benefit associated with lymphadenectomy in high-risk patients.	2b
In patients unfit for surgery with massive haematuria or flank pain, embolisation can be a beneficial palliative approach.	3

Recommendations	Strength rating
Offer surgery to achieve cure in localised renal cell cancer.	Strong
Offer partial nephrectomy to patients with T1 tumours.	Strong
Do not perform ipsilateral adrenalectomy if there is no clinical evidence of invasion of the adrenal gland.	Strong
Offer an extended lymph node dissection to patients with adverse clinical features, including a large diameter of the primary tumour.	Weak
Offer embolisation to patients unfit for surgery presenting with massive haematuria or flank pain.	Weak

Renal Mass and Localized Renal Cancer[1]



Evaluation/Diagnosis

1. Obtain high quality, multiphase, cross-sectional abdominal imaging to optimally characterize/stage the renal mass.
2. Obtain CMP, CBC, and UA. If malignancy suspected, metastatic evaluation should include chest imaging and careful review of abdominal imaging.
3. Assign CKD stage based on GFR and degree of proteinuria.

Counseling

1. A urologist should lead the counseling process and should consider all management strategies. A multidisciplinary team should be included when necessary.
2. Counseling should include current perspectives about tumor biology and a patient-specific oncologic risk assessment. For cT1a tumors, the low oncologic risk of many small renal masses should be reviewed.
3. Counseling should review the most common and serious urologic and non-urologic morbidities of each treatment pathway and the importance of patient age, comorbidities/frailty, and life expectancy.
4. Physicians should review the importance of renal functional recovery related to renal mass management, including risk of progressive CKD, potential short/long-term need for dialysis, and long-term overall survival considerations.
5. Consider referral to nephrology in patients with a high risk of CKD progression, including those with GFR < 45^2, confirmed proteinuria, diabetics with preexisting CKD, or whenever GFR is expected to be < 30^2 after intervention.
6. Recommend genetic counseling for all patients ≤ 46 years of age and consider genetic counseling for patients with multifocal or bilateral renal masses, or if personal/family history suggests a familial renal neoplastic syndrome.

Renal Mass Biopsy (RMB)

1. RMB should be considered when a mass is suspected to be hematologic, metastatic, inflammatory, or infectious.
2. RMB is not required for: 1) young/healthy patients who are unwilling to accept the uncertainties associated with RMB; or 2) older/frail patients who will be managed conservatively independent of RMB.
3. Counsel regarding rationale, positive/negative predictive values, potential risks and non-diagnostic rates of RMB.
4. Multiple core biopsies are preferred over FNA.

Management

Partial Nephrectomy (PN) and Nephron-Sparing Approaches

1. Prioritize PN for the management of the cT1a renal mass when intervention is indicated.
2. Prioritize nephron-sparing approaches for patients with an anatomic or functionally solitary kidney, bilateral tumors, known familial RCC, preexisting CKD, or proteinuria.
3. Consider nephron-sparing approaches for patients who are young, have multifocal masses, or comorbidities that are likely to impact renal function in the future.

Radical Nephrectomy (RN)

1. Physicians should consider RN for patients where increased oncologic potential is suggested by tumor size, RMB, and/or imaging characteristics. In this setting, RN is preferred if all of the following criteria are met:
1) high tumor complexity and PN would be challenging even in experienced hands;
2) no preexisting CKD/proteinuria; and
3) normal contralateral kidney and new baseline eGFR will likely be > 45^2.

Thermal Ablation (TA)

1. Consider TA an alternate approach for management of cT1a renal masses <3 cm in size. A percutaneous approach is preferred.
2. Both radiofrequency ablation and cryoablation are options.
3. A RMB should be performed prior to TA.
4. Counseling about TA should include information regarding increased likelihood of tumor persistence/recurrence after primary TA, which may be addressed with repeat TA if further intervention is elected.

Active Surveillance (AS)

1. For patients with renal masses suspicious for cancer, especially those <2cm, AS is an option for initial management.
2. Prioritize AS/Expectant Management when the anticipated risk of intervention or competing risks of death outweigh the potential oncologic benefits of active treatment.
3. When the risk/benefit analysis for treatment is equivocal and the patient prefers AS, physicians should repeat imaging in 3-6 months to assess for interval growth and may consider RMB for additional risk stratification.
4. When the oncologic benefits of intervention outweigh the risks of treatment and competing risks of death, physicians should recommend active treatment. In this setting, AS may be pursued only if the patient understands and is willing to accept the associated oncologic risk

Factors Favoring AS/Expectant Management

Patient-related	Tumor-related
Elderly	Tumor size <3cm
Life expectancy <5 years	Tumor growth <5mm/year
High comorbidities	Non-infiltrative
Excessive perioperative risk	Low complexity
Frailty (poor functional status)	Favorable histology
Patient preference for AS	
Marginal renal function	

Principles Related to PN

1. Prioritize preservation of renal function through efforts to optimize nephron mass preservation and avoidance of prolonged warm ischemia.
2. Negative surgical margins should be a priority. The extent of normal parenchyma removed should be determined by surgeon discretion taking into account the clinical situation; tumor characteristics including growth pattern, and interface with normal tissue. Enucleation should be considered in patients with familial RCC, multifocal disease, or severe CKD to optimize parenchymal mass preservation.

Surgical Principles

1. In the presence of clinically concerning regional lymphadenopathy, lymph node dissection should be performed for staging purposes.
2. Adrenalectomy should be performed if imaging and/or intraoperative findings suggest metastasis or direct invasion.
3. A minimally invasive approach should be considered when it would not compromise oncologic, functional and perioperative outcomes.
4. Pathologic evaluation of the adjacent renal parenchyma should be performed after PN or RN to assess for possible nephrologic disease, particularly for patients with CKD or risk factors for developing CKD.

---

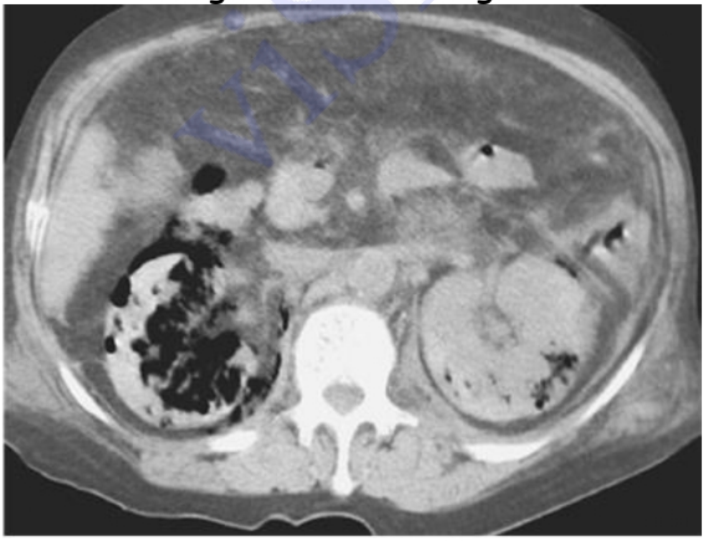
1. Focus is on clinically localized renal masses suspicious for RCC in adults, including solid enhanced tumors and Bosniak 3 and 4 complex cystic lesions. 2. ml/min/1.73m^2

53. A healthy 32-year-old female with no prior history of urolithiasis wishes to donate a kidney to her 33-year-old husband, who has esrd due to congenital reflux nephropathy. On ct scan evaluation, she is found to have a 1.5-mm calculus in the right renal pelvis. The metabolic stone workup is normal. Which of the following statements is true?

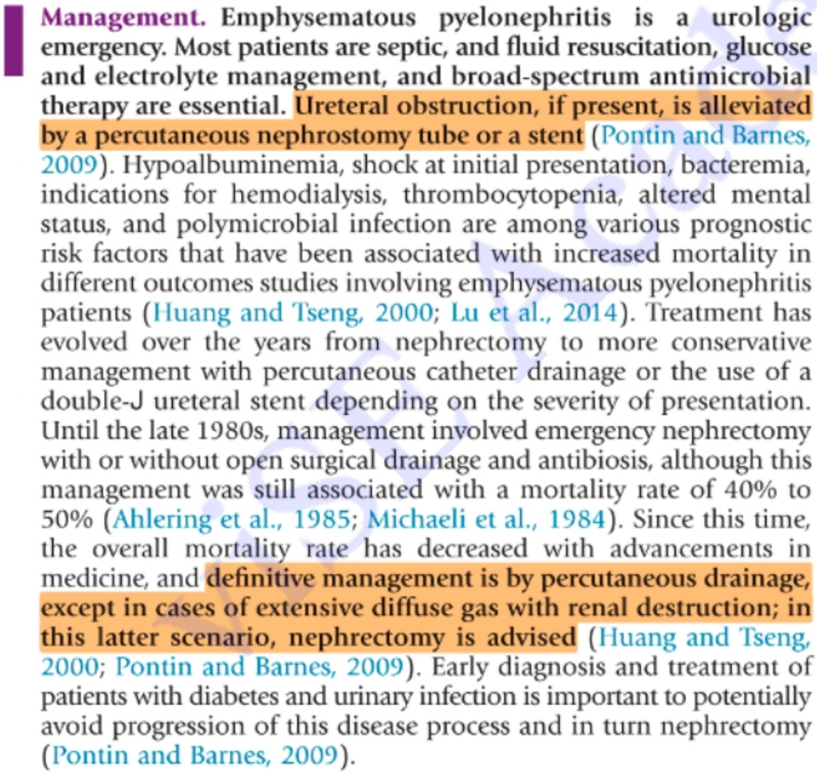
A. She cannot donate her kidney because of her renal stone.
B. She should be accepted as a donor, and the left kidney should be removed for donation.
C. She may be considered for donation of the right kidney.
D. She cannot donate because of her husband's etiology of esrd.
Answer: C
Explanation: Campbell Text Book Of Urology 11th Edition, Chapter No.47, Page No. 1078

This question is a direct pick up from Campbell Board Review.

54. 45 year old female presented with fever , right loin pain and was evaluated—her TLC 21000 and FBS 203 and the CECT IMAGE is shown below (gas in renal parenchyma and large stone in the pelvis). What is the best diagnosis and management



A. Emphysematous pyelonephritis & manage with percutaneous drainage
B. Pyonephrosis, percutaneous drainage
C. Perinephric abscess open exploration
D. Emphysematous pyelonephritis & manage with open exploration
Answer: A
Explanation: VISE URO MOCK 2 Q 68 (CT image based question of Identification of Emphysematous pyelonephritis given)
Campbell Text Book Of Urology 12th Edition, Chapter No. 55, Page No. 1173



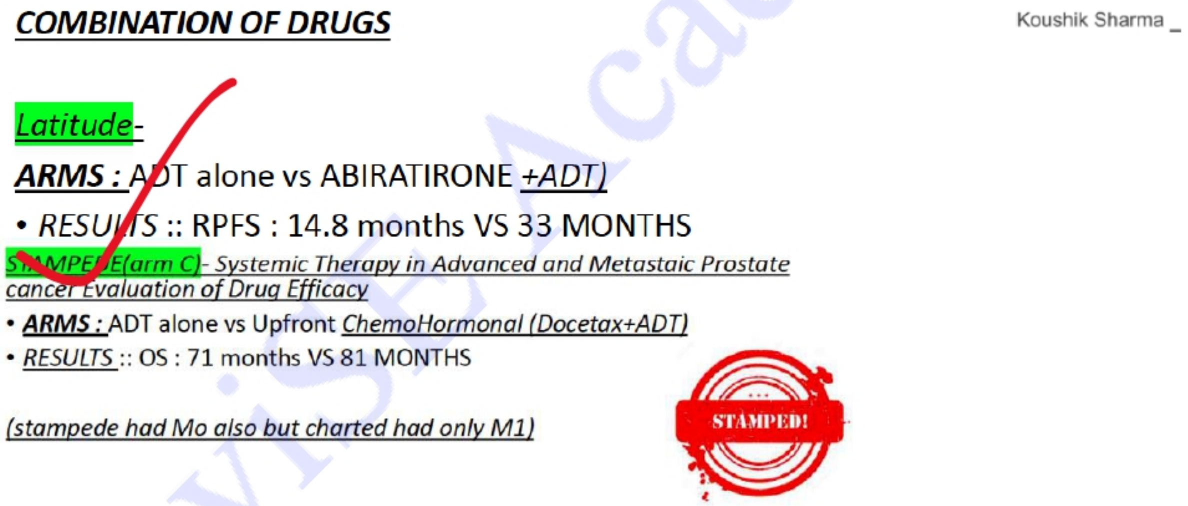
Management. Emphysematous pyelonephritis is a urologic emergency. Most patients are septic, and fluid resuscitation, glucose and electrolyte management, and broad-spectrum antimicrobial therapy are essential. Ureteral obstruction, if present, is alleviated by a percutaneous nephrostomy tube or a stent (Pontin and Barnes, 2009). Hypoalbuminemia, shock at initial presentation, bacteremia, indications for hemodialysis, thrombocytopenia, altered mental status, and polymicrobial infection are among various prognostic risk factors that have been associated with increased mortality in different outcomes studies involving emphysematous pyelonephritis patients (Huang and Tseng, 2000; Lu et al., 2014). Treatment has evolved over the years from nephrectomy to more conservative management with percutaneous catheter drainage or the use of a double-J ureteral stent depending on the severity of presentation. Until the late 1980s, management involved emergency nephrectomy with or without open surgical drainage and antibiosis, although this management was still associated with a mortality rate of 40% to 50% (Ahlering et al., 1985; Michaeli et al., 1984). Since this time, the overall mortality rate has decreased with advancements in medicine, and definitive management is by percutaneous drainage, except in cases of extensive diffuse gas with renal destruction; in this latter scenario, nephrectomy is advised (Huang and Tseng, 2000; Pontin and Barnes, 2009). Early diagnosis and treatment of patients with diabetes and urinary infection is important to potentially avoid progression of this disease process and in turn nephrectomy (Pontin and Barnes, 2009).

55. LATITUDE TRIAL is related to which drug
A. Enzalutamide In Metastatic crpc With Increase In Pfs
B. Docetaxel In Hormone Resistant With Increase In Os
C. Abiraterone In Hormone Sensitive With Increase In Os
D. Abiraterone In Locally Advanced Prostate Cancer With Increase In Pfs

Answer: C
Explanation: VISE URO LECTURE NOTES-426 THE STAMP/THAPPA MENMONIC FOR PROSTATE STUDIES

VISE URO MOCK 1 Q 72

72. IMPACT trial for Sipuleucel -T Sipuleucel -T



COMBINATION OF DRUGS

Koushik Sharma

Latitude-

ARMS : ADT alone vs ABIRATIRONE *+ADT)*

- *RESULTS* :: RPFS : 14.8 months VS 33 MONTHS

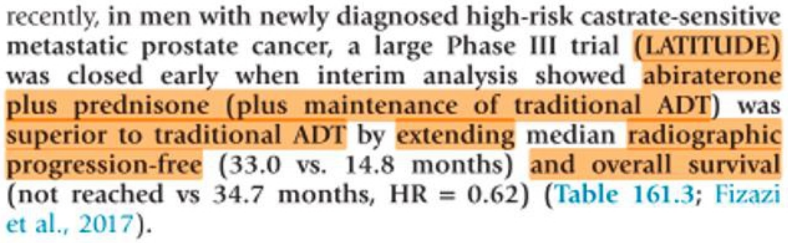
STAMPEDE(arm C)- Systemic Therapy in Advanced and Metastaic Prostate cancer Evaluation of Drug Efficacy

- **ARMS :** ADT alone vs Upfront *ChemoHormonal (Docetax+ADT)*
- *RESULTS* :: OS : 71 months VS 81 MONTHS

(stampede had Mo also but charted had only M1)

STAMPED!

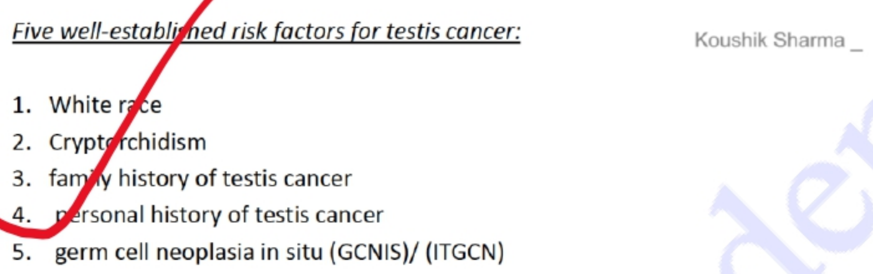
Campbell Text Book Of Urology 12th Edition, Chapter No. 161, Page No. 3678



recently, in men with newly diagnosed high-risk castrate-sensitive metastatic prostate cancer, a large Phase III trial (LATITUDE) was closed early when interim analysis showed abiraterone plus prednisone (plus maintenance of traditional ADT) was superior to traditional ADT by extending median radiographic progression-free (33.0 vs. 14.8 months) and overall survival (not reached vs 34.7 months, HR = 0.62) (Table 161.3; Fizazi et al., 2017).

56. Not an established risk factor for testicular malignancy
A. Microlithiasis
B. Family h/o
C. Personal h/o
D. ITGCN
Answer: A
Explanation:

VISE URO LECTURE NOTES—CA TESTIS -page-1

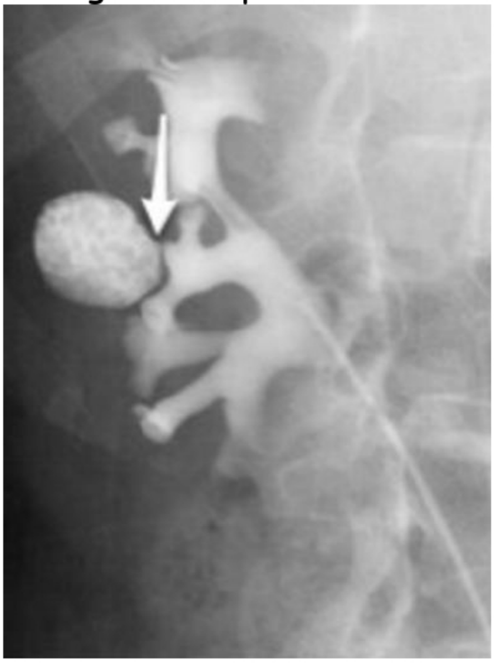


Five well-established risk factors for testis cancer:

Koushik Sharma _

1. White race
2. Cryptorchidism
3. family history of testis cancer
4. personal history of testis cancer
5. germ cell neoplasia in situ (GCNIS)/ (ITGCN)

57. In the IVP s/o Large calyceal diverticular stone below the Best management option is ?



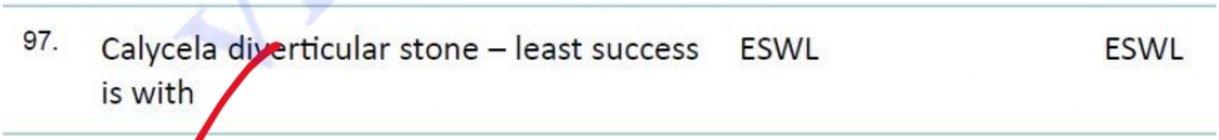
A.ESWL
B. PCNL
C. Open surgery with excision of diverticula
D. fURS

Answer : B

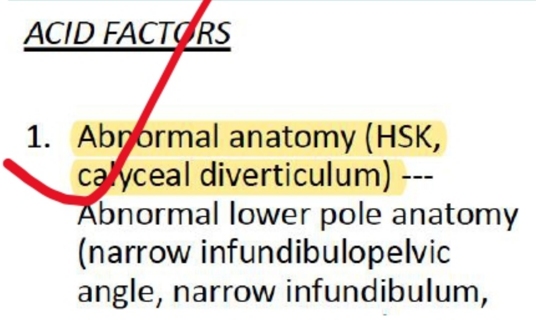
Explanation: Vise Mock test series- 2 Question no-97

VISE URO LECTURE NOTES- STONE-106-

ACID FACTOR MNEMONIC

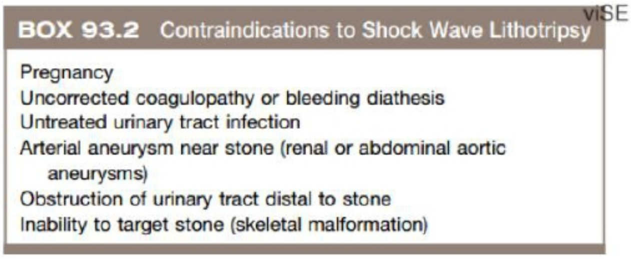


97.	Calycela diverticular stone – least success is with	ESWL	ESWL



ACID FACTORS

1. Abnormal anatomy (HSK, calyceal diverticulum) --- Abnormal lower pole anatomy (narrow infundibulopelvic angle, narrow infundibulum,



BOX 93.2 Contraindications to Shock Wave Lithotripsy

Pregnancy
Uncorrected coagulopathy or bleeding diathesis
Untreated urinary tract infection
Arterial aneurysm near stone (renal or abdominal aortic aneurysms)
Obstruction of urinary tract distal to stone
Inability to target stone (skeletal malformation)

viSE

58. Which of the following statements regarding renal handling of acid is FALSE?

a. Most bicarbonate is reabsorbed in the distal collecting tubule.

b. Lungs can excrete volatile acid, but the kidneys must excrete fixed acid.

c. Carbonic anhydrase catalyses the production of H+ and HCO_3^- from H_2O and CO_2.

d. Chronic respiratory acidosis should lead to increased H+ in the kidney.

Answer : A

Explanation: Most bicarbonate is reabsorbed in the distal collecting tubule.

Most bicarbonate reabsorption in the kidney occurs in the proximal tubule.

This question is DIRECT PICK UP FROM CAMPBELL BOARD REVIEW (chapter 86, question no 6)

VSE Academy

59. 30 year old man with 1.5 cm pelvis stone, want to undergo RIRS for stone removal, which of the following is true:

A. With basket intact stone is taken out

B. Semirigid RIRS use rod lens system

C. Fibre-optic cable mc used in flexible RIRS

D. ESWL more invasive than RIRS

Answer. C

Solution. Smith Endourology- chapter 468

Urology instrumentation Comprehensive Guide- Sabnis-page .no 10

Option B is false as semirigid, uses Fiber-optics and not Rod lens

The Rod-lens System (Figure 9)

In 1966, the collaboration between Karl Storz and Professor HH Hopkins led to the new design of rod-lens system. This was a major development for the progress of endourology since the description of cystoscope by Maximilian Nitze.

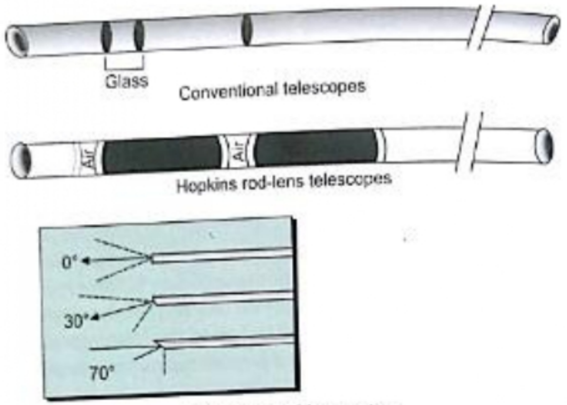


Figure 9: Rod-lens system

Semirigid ureteroscopes

Endoscopic evolution

Developed in the early 1980s, the Rigiflex ureteroscope by ACMI had a straightened eyepiece for introducing the scope into the ureter and later offset to admit the ultrasonic lithotripter. The ACMI HTO-5 was unique in being the first ureteroscope to incorporate fiber-optic imaging technology to produce the flexible "gooseneck" eyepiece. Although the scope had a 12.7 Fr diameter shaft and a 5 Fr single working channel, comparable rod–lens ureteroscopes of the time with a 5 Fr channel were 14.5–15 Fr in size.

Ureterorenoscopy with a rigid scope still had inherent problems with the rod–lens optics due to the tortuous nature of the ureter and the caliber and working length of the instrument, which gave impaired vision. With the growing demand for rigid ureteroscopes in the 1980s, the further use of fiber-optic technology enabled further miniaturization of the shaft diameter along with reduction in size of the working channels. The "miniscope" or semirigid ureteroscope combined smaller working channels and fiber-optics, allowing both illumination and image incorporated into a metal sheath. The optical system was reduced in size compared with the rod–lens design, leading to its primary advantage, an overall reduction in the outside diameter of the scope, but not at the expense of reducing the size of the working channels

60. A 60 year old Male presented with complain of urgency frequent and dysuria for the past 2 wk. His serum PSA was 5ng/dl. Wht should be done next

A. Repeat psa after 6 wk
B. Turp
C. Trus guided biopsy
D. mpMRI

Answer: D

28/58 Urology questions from viSE lectures/mnemonics
20/58 Urology questions from viSE urology mock tests
14/40 General Surgery questions from viSE General Surg mock tests

Contact us at: 9014516775
Follow us at:
UROLOGY: https://www.facebook.com/viseurology/
GENERAL SURGERY : https://www.facebook.com/viseGeneralSurgery/
GI SURGERY: https://www.facebook.com/viseGISURGERY/

Stay Tuned for viSE GENERAL SURG Comprehensive Course
(BAILEY & SABISTON BASED ONLINE MCQ COURSE)

Stay Tuned for viSE Urology Comprehensive Course
(LECTURE SERIES + COMPREHENSIVE ONLININE MCQ COURSE)

(हासिल-Urology 2.0)

(Hasil-Urology 2.0)